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CHANGES IN OCCUPATIONAL THERAPY DUE TO THE TRANQUILIZING DRUGS

H. K. ELKINS, M.D.*
N. MERYL VAN VLACK, O.T.R.**

The introduction of the tranquilizing drugs in the treatment of neuropsychiatric patients in the past two years has resulted in changes affecting almost all aspects of hospital care. The wide use of reserpine, chlorpromazine, and meprobamate has brought about a quieter hospital population with fewer assaults, AWOL's and instances of destructive behavior. Many patients who have constituted a difficult problem in hospital management are now able to accept their hospitalization for the positive benefits which it offers. Reappraisals of the changing role of security measures, use of hydrotherapy, the relative place of other drugs such as the barbiturates, the uses of recreation, activity treatment and other therapy functions seem to be indicated.

The effects which tranquilizing drugs have are primarily those of reducing "tension." There is less need for the patient to keep "on guard" and many of the protective devices, physical and psychological, such as combative behavior, withdrawal and delusional thinking, which the patient has hitherto developed for defense purposes, diminish.

Because drugs have decreased tension for many patients and lessened the need for abnormal defenses, they are now better able to relate in more normal patterns. The most important result is the greater accessibility of many patients to psychotherapy and to the various forms of ancillary treatment. Patients who respond favorably to the tranquilizing drugs have shown a raised level of ability and desire to participate in hospital activities. New demands are placed on the hospital services responsible for providing these activities, demands which affect not only the extent and range of activity available, but also the level of performance at which they are aimed.

The purpose of this paper is to cite some of the changes observed in "tranquilized" patients in the occupational therapy clinics of the Veterans Administration Hospital, Palo Alto, California, and to report how these changes have affected the role of occupational therapy.

This hospital, a 1400 bed neuropsychiatric teaching hospital, treats veterans only, 98% of whom are male, most of them with psychoses in varying degrees and lengths of illness. Approximately half of the population has been on one or more of the tranquilizing drugs during the past two years. It is difficult to generalize about the beneficial effects of drug therapy, since many variables exist, including the kinds, extent and quality of other therapy also available to such a population, but it is our impression that drug therapy, per se, can be expected to cause a general improvement of significant degree in approximately one-half of the patients treated.

Early in treatment, one of the common side-effects is that of excessive somnolence to the point where the patient may need to be frequently prompted, reminded or even roused in order to carry out usual hospital routine.

This is sometimes followed or accompanied by a period of inner turbulence or unrest in which the patient complains that he feels as though he should act on some inner painful propulsion but is physically unable to do so. Once the early somnolent and turbulent periods are passed, and once optimal dosage is established for the patient, more lasting improvement becomes evident. Our report is based on changes in those

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patients who have responded favorably to tranquilizing drugs after this initial period.

It is difficult to separate or classify the elements in this improvement, but for the occupational therapist three elements of change seem pertinent: (1) diminished hyperactivity, assaultiveness, and destructive behavior; (2) a raised level of comprehension and interest for objects and people in the environment; (3) an increase in attention span and the ability to plan for goals.

We should like to discuss these changes as though they were separate entities and indicate in summary how they have somewhat altered the role of occupational therapy in our neuropsychiatric hospital.

1. *Diminished hyperactivity, assaultiveness, and destructive behavior.*

The occupational therapy clinic is experiencing, as all areas in the hospital have been pleased to note, fewer and less severe episodes of hyperactivity and destructive behavior. Verbal arguments and exchanges of blows between patients are now unusual occurrences. Rarely are windows broken, materials destroyed in anger, or hospital property defaced or damaged. There is less profane language, indiscriminate urination in the clinic or overt exposure and masturbation.

Much less occupational therapy prescription to gross activity, such as loom work, pounding and tearing materials to relieve tension, is necessary. Prompting and reminding for those patients heavily tranquilized are frequently necessary during the early period of medication, but such prompting is better understood and accepted by the patient.

During the pre-drug era, much of the occupational therapist's time, tact and ingenuity have been directed towards channeling excessive drives and controlling hyperactivity. Sensitive and skilled therapists were able to devise a repertoire of techniques which were useful in handling threatened or overt hostility in a therapeutic manner. Today such a repertoire or "stock in trade" is rarely used.

There is much less need for restriction and control for many of the routine operating procedures. Fewer clinic doors are locked and more tool cabinets may be left open for patient use. Scrutiny and direct supervision of tool use has decreased and those patients who do use tools accept greater responsibility for their return at the end of the clinic hour. Despite these lessened controls, A.W.O.L.'s from the clinic are infrequent and the surreptitious concealment or taking of tools from the occupational therapy clinic to the ward is a rare occurrence.

Because of wider freedom throughout the hospital, as well as in the occupational therapy clinic, and because of the patients' better ability to handle such freedom, a great deal more self-determined behavior becomes possible. Patients are better able to select the type of work they want to do without the need for restrictions, and more and better quality creative productions result.

The most important result of these decreased controls is that the patient is provided with a new meaning regarding his hospitalization. He is better able to see himself accepted as a person and not as someone to be guarded and feared. For mentally ill persons, already fearful of their own impulses and the dangers from within, this acceptance can be a major factor in treatment.

2. *A raised level of comprehension and interest for objects and people in the environment.*

Most dramatic of the changes noted in patients on drug therapy is their general increased ability to take interest for the first time in objects and people outside themselves. Objects poorly comprehended or erroneously interpreted in the past now become better recognized for their reality. The patient recognizes paper, crayons, plastics and other material for their reality; he calls them by their correct names, and uses them in a more appropriate manner. There is less crayon eating, less stuffing of waste papers and materials into the mouth, pockets or other orifices. Better comprehension and interest in external objects is a direct corollary to less self-interest and the patient is less likely to masturbate publicly, overtly hallucinate, day-dream, or withdraw into apathetic silence.

One of the difficult problems for the occupational therapist in the past has been that of helping the patient discover and develop an interest in things outside himself. To accomplish this, the occupational therapist has had to explore lengthily the many possibilities of a patient's potential interest. Today we find that this exploratory period is shortened. The patient is able at a much earlier date to comprehend his surroundings, select something which interests him and establish a purposeful relationship with his choice.

The occupational therapy clinic is more apt to be understood as a place of treatment activity and the occupational therapist herself is recognized for his true role. His name becomes something by which patients can identify him. His resources as a teacher and guide are called upon. His craft knowledge is more needed and respected and his opinions and attitudes about aspects of hospital life, other hospital personnel, the patient's personal life, ideas and personal feelings are more freely and frequently sought. The occupational therapist is thus drawn by the patient into the wider role of reality tester.

In order to win the occupational therapist as a participant in reality testing, the patient strives

harder to win approval, much in the same way as he may react to a psychotherapist whom he values. He responds more readily to the occupational therapist's standards by becoming more tidy, watching his speech more carefully, and generally attempting to live up to the expectations of others.

In group treatment, most patients are better able to understand the rights and feelings of others. Patients on tranquilizing drugs become aware more quickly and more acutely of what is going on in a group and are apt to join as active participants with constructive rather than destructive purposes.

In the past, occupational therapists have frequently made use of "habit training" for regressed psychotic patients. Such habit training makes possible the mechanical carrying out of routine: the coming and going from ward to clinic, and the simple housekeeping procedures at the beginning and end of occupational therapy clinic hours. Such "training" has "conditioned" the patient to carry out other simple functions of personal hygiene and hospital care, and although necessary and useful to prevent further regression, has frequently given the impression of mechanical movement or simple reflex action.

Today, habit training is practically passe. Most patients now carry out hospital routine without special training, often showing appropriate affect to what they are doing. Their gait is quicker, they give the impression of knowing where they are going as they move about the hospital grounds or in the occupational therapy clinic, and the old "asylum trudge" typified by bent back, rigid shoulders, and shuffling gait, is fast disappearing from the hospital scene.

3. *An increase in attention span and the ability to plan for goals.*

Those patients successfully treated by tranquilizing drugs are not only able to show interest in their surroundings, but maintain this interest. Span of attention is greatly increased. Interest from one clinic hour holds over to the next and the brief one-time occupational therapy project has infrequent value in the clinic of today.

In the past, the occupational therapist has experienced great difficulty in explaining to the patient what a product would or should look like upon completion. Only the present tense could be understood and the ability to project into the future seemed lacking for most psychotic patients. Today, patients seem better able to visualize an unfinished product in its future entirety, are better able to comprehend the various steps involved in its completion, and are able to maintain interest as they pass from one step to the next while working at it. Goals may be planned for and attained.

One result of the patient's new ability to plan for goals is his desire for better quality materials with which he can work. Scraps and second-rate materials which might well serve for single-process usage, but which have no useful end product in view, will be rejected by patients.

Not only is the patient capable of projecting his productions into the future, but he frequently projects himself. He considers for the first time since his illness what will become of him. He may reveal this concern about his future by discussing it with the occupational therapist or by requesting progressive assignments which involve greater responsibility.

Changes such as these in patients who have responded favorably to tranquilizing drugs, have resulted in a number of altered demands upon the occupational therapist. Re-evaluation of the present-day role of occupational therapy in the neuropsychiatric hospital seems indicated, since on the one hand some procedures traditionally used by occupational therapy are little called for today while on the other hand a host of greater and somewhat different patient demands now exist.

CONCLUSIONS

Changes in the role of occupational therapy may be summarized as follows: Because of *lessened patient hyperactivity and assaultiveness* there is less need for the occupational therapist to use such control measures as locked clinic doors or tool cabinets. This should not mean that precautionary measures can be forgotten, but rather that the occupational therapist is now freer for other therapeutic effort. Less of the occupational therapist's time will be necessary for using gross sedative activity.

The occupational therapist is now able to allow more freedom to the patient in his selection of activity. There is greater reason than before for the occupational therapist to view the patient, not in terms of his rational or irrational behavior nor in terms of his ability or lack of ability to handle crafts, but rather as a person who needs help in attaining his highest level of social adjustment.

An additional responsibility of the occupational therapist is that of observing and reporting the side-effects of medication. The side-effects, especially during the initial induction period, range from excessive somnolence and inner turbulence to gastro-intestinal upsets, dermatitis and rarely convulsive episodes. This responsibility the occupational therapist shares with the nurse and the psychiatric aide.

Because of patients' better ability to comprehend objects and take interest in surroundings, there will be less need for simple habit training

programs. Activities must be offered which provide realistic application to normal life. Simple craft work which cannot be linked to wider utilitarian value in the patient's life is probably on the decline. He will want none of this unless he views his entire hospitalization as fill-in time and a release from the realities of living.

The occupational therapist will be severely tested for his craft knowledge for he is being used more than ever before as a teacher and technician by the patient. His knowledge and understanding of psychotherapy will also be tried inasmuch as he is drawn more intimately by the patient into the role of reality tester.

The raised level and the increased number of patient needs require more of the occupational therapist's time. Even in small clinics, it is already evident that additions to the occupational therapy staff or additions of well-qualified volunteers are necessary.

Because of patients' increased attention span and ability to plan for goals, activities must be offered which require more complex skills and better planning for the patient. Better quality material will have to be available and the occupational therapist must be alert for the quicker progression of the patient to activities which require greater responsibility.

All clinical observers point out that the new tranquilizing drugs do not offer a substitute for other forms of therapy. Such procedures as EST, use of hydrotherapy, sedative drugs, and other control measures have decreased within the hospital, whereas the demand for those aspects of treatment which provide re-learning, re-socialization and vocational opportunity are now in greater demand than ever before. Most physicians will depend largely upon the occupational therapist to help capitalize on the gains made through the tranquilizing drugs.

There is ample recognition today of the increasing need for all ancillary therapies. Some clinicians were quick to point this out during the very early period of tranquilizing drug use; e.g., the following remarks:

"This drug [the authors were reporting on reserpine] demands that every other therapeutic resource available be used intelligently in the further treatment of our patients for the patients who respond [to reserpine] are now more accessible to such therapy . . . Rather than solving the difficult problems of hospital treatment of the mentally ill, the availability of a drug such as this introduces grave problems for the conscientious hospital administrator, psychiatrist, and nurse. We believe it will be found that while the burdens of caring for the disturbed are lessened . . . , the challenge of providing appropriate additional psychiatric treatment for those no longer disturbed will tax all of our ingenuity, skill and resources."[1]

We would add that the occupational therapist and all those in the hospital responsible for providing realistically oriented activities must be aware of the challenge presented by the tranquilizing drugs if we are going to meet it.

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ALL ABOARD

This is the last chance for you to "get on board" for the 1957 institute-conference at Cleveland, Ohio, October 21-25, 1957. We hope you have sent in your pre-registration cards, hotel reservations and are packing your bags while reading this communique. Speaking of packing, be sure to bring fall clothes with you. Cleveland's weather is quite unpredictable, but winter coats are not ordinarily in order in October. However, suits and light weight coats make for comfortable dressing.

The "welcome mat" has been dusted off. Programs, pencils and paper are waiting at the registration desk. We promise to keep you busy and interested throughout the week, from the opening coffee hour to the last group session, where you can all take part and share with others.

We'll be looking for you at the Hotel Carter, the headquarters for the 40th anniversary AOTA institute-conference. See you there!

THE EFFECT OF THE PROFESSIONAL ACTIVITY OF THE OCCUPATIONAL THERAPIST ON THE BEHAVIOR OF ACUTE MENTAL PATIENTS [1] [2]

G. DONALD NISWANDER, M.D.
GEORGE M. HASLERUD, Ph.D.
EILEEN DIXEY, O.T.R.[3]

In chronic mentally ill patients it was found that the occupational therapist is indispensable for establishing the work atmosphere and utilizes the greater part of the time gaining rapport and encouraging the patient to work rather than demonstrating or explaining craft skills.[1] A test of this conclusion as it relates to acute mentally ill patients in a regular occupational therapy clinic was incorporated as part of an experiment of behavior when reserpine was administered to the patient.[2] As in the earlier study, the role of the occupational therapist was examined by comparing the behavior of patients when the therapist was performing ordinary professional activity, with those periods when the therapist was completely withdrawn or passive in the clinic and all initiative was left to the patients. The use of the occupational therapy clinic as a laboratory for studying behavior was suggested by Hyde, et al.[3, 4]

Ten male and ten female patients, who were recent admissions to the hospital, were selected for the study. The age range was from 22 to 65 years, with a median age of 41 years. Length of time in the hospital for the group of patients varied from 3 to 98 days, with a median hospitalization time of 13.5 days. In the earlier study with the chronic patients, the median age was 46 years, and the median duration of hospitalization was 10 years.

A female occupational therapist and a female occupational therapy student had charge of the clinic for the ten acutely ill male patients; and a similar pair of therapists had charge of the clinic for the ten acutely ill female patients. Each clinic met for a 50-minute session three mornings a week for seven weeks, giving a total of 21 sessions. Each session was divided into three parts; in the first and third parts of each session the therapist and her assistant performed their normal clinic roles, but in the middle third of each session they were instructed to assume a passive role, and only to respond to questions and give aid when asked by the patients.

Observations were made on patients and therapists by means of a time-sampling technique, whereby the observer noted each patient's activity for a 10-second interval, and then took 20 seconds to record these ratings on appropriate scales. Each of the ten patients was observed in turn, and then the therapist and her assistant; each individual had seven 10-second time samplings of his behavior in each 50-minute session. The observer in each of the male and female clinics was a male psychology graduate student; he was seated in a remote section of the clinic which, however, afforded him a view of each patient; he would respond to patient's questions but would never initiate conversation.

The patients were rated on four scales—activity, socialization, combined activity and withdrawal—as described in the reserpine study.[2] The therapists were rated on the categories given in Table I. Only the single principal activity was checked at each time sampling interval in this present study, as contrasted with checking all observed activities in the earlier study.[1]

Reliability for the occupational therapists' categories was pre-tested by having each observer rate independently the activity of the same two therapists within a given clinic. The coefficient of .91 shows that the categories were sufficiently objective to allow the observers to rate the therapists consistently.

RESULTS

At the left of Table I, which deals with results with acute patients, the summed ratings of the behavior of the two therapists and their student

1. From the Arthur P. Noyes Institute for Neuropsychiatric Research, New Hampshire State Hospital, Concord, New Hampshire.
2. The authors are indebted to Nathan Brody, and Thomas M. Casey, who acted as the observers in the occupational therapy clinics, and who assisted in the preparation of the manuscript. The authors acknowledge the cooperation of Mrs. Martha Wickham, O.T. Reg., and Miss Sarah Thorndike, O.T.R., the occupational therapists; Miss Jean Clagett and Miss Ardena Grannis, occupational therapy student assistants; and the research council of the New Hampshire State Hospital, for helpful suggestions while planning the study.
3. Dr. Niswander is director of psychiatric education and research at the New Hampshire State Hospital. Dr. Haslerud is professor of psychology, University of New Hampshire, and research consultant to the New Hampshire State Hospital. Miss Dixey is director of the occupational therapy department of the New Hampshire State Hospital.

assistants are compared for the experimentally passive (P) and professionally active (A) periods. Apparently the directions concerning the therapists' role were followed because we see a large difference in the task-centered conversation and activity between A and P. It would seem that there had been a significant shift of behavior to an increase of routine, such as dealing with records and supplies, or absent-minded withdrawal from the patients during the passive (P) periods. On the right of Table I is a rearrangement of the data in the earlier study with chronic mentally ill patients.[1] To make comparisons possible with the present study, the multiple ratings were given, as a rough approximation, fractional values, e.g., if three categories had been checked, each was given 33 per cent. With the acute patients 55 per cent of the time was task-centered compared with 35.1 per cent in the chronic group. On the other hand, with the acute patients there were no samplings of "interested observations of patients" and "encouragement," which in two categories had amounted to 43.4 per cent of the therapists' time with the chronic group. There was also half again as much time on non-task conversation between the therapist and the chronic patients, as with acute patients (19.5 per cent versus 12.6 per cent). The earlier study with the chronic patient was pre-arranged and experimentally controlled so that routine duties were almost entirely eliminated in contrast to their large representation in the regular clinic in this study.

COMPARISON OF ACTIVITIES OF OCCUPATIONAL THERAPISTS IN CLINICS OF ACUTE AND CHRONIC MENTALLY ILL PATIENTS

	ACUTE GROUP "P" (162 Periods)	"A" (326 Periods)	*CHRONIC GROUP* "A" (216 Periods)		
Task-centered conversation and activity	27.8%	55%	Suggestion of tasks Description of tasks Participation in tasks	14.0% 10.8% 10.3%	35.1%
Task and non-task complimentary	0%	0%	Interested observation of patients Encouragement	26.2% 17.2%	43.4%
Non-task conversation	10.5%	12.6%	Non-task conversation		19.5%
Withdrawal from patients (absent minded, coercion, etc.)	13%	3.4%	Withdrawal		0
Clinic routines (answering telephone, keeping records, etc.)	46.3%	28.4%	Clinic routine (prearranged)		2.3

TABLE I

Tables II and III deal entirely with the results of the present study. Table II indicates that in both the male and female clinics the constructive occupational therapy task-centered work went on at the same level during the passive periods, as when the therapist was professionally active. The slight differences between roles are insignificant. On the other hand, when the male clinic is compared to the female clinic the differences are significant. This difference seems to be accounted for by the fact that the occupational therapy tasks in the clinic were of a different nature. In the male clinic the patients were engaged in tasks which were more challenging and with which they had had no previous experience (leatherwork, weaving, etc.). In the female clinic the tasks were mostly those crafts with which the patient was already familiar (knitting, embroidery, etc.).

Whether the passive or active behavior of the therapist affects the social behavior of the patient is shown in Table III. There is clear indication of some initiative by patients during the therapists' passive periods, but the percentage of time spent verbalizing is not large at any of the periods. The percentage of time when patients were speaking to a therapist declines one-third when the therapist is passive. At the same time, interaction with other patients increases for the females by one-third and decreases for the males by one-half (compare A and P).

DISCUSSION

The results indicate that the behavior of the occupational therapist affects the acute patients' sociability, but not the patients' activity on occupational therapy tasks. This contrasts greatly with the sensitivity of the chronic patients to the behavior of the therapist, in that when the role of the therapist changed from active to passive in the chronic group, both socialization and activity of the patients decreased by 40 per cent; conversely, when the role of the therapist changed from passive to active, both activity and socialization increased to its previous or even higher level.[1] The non-appearance of complimentary or evaluative behavior and the lower amount of non-topical conversation on the part of the therapist in the acute groups compared to their majority position with the chronic patients needs

COMPARISON OF CONSTRUCTIVE OCCUPATIONAL THERAPY ACTIVITY IN ACUTE PATIENTS (EXPRESSED IN PERCENTAGE OF SAMPLING PERIODS) BETWEEN THE THERAPISTS' ROLE AS PROFESSIONALLY ACTIVE (A) AND EXPERIMENTALLY PASSIVE(P)

Clinic	Number of Periods	"A" Period	"P" Period
Male	368	68.4%	71.6%
Female	392	54.4%	57.4%

TABLE II

COMPARISON OF VERBAL SOCIAL BEHAVIOR IN ACUTE PATIENTS (EXPRESSED IN PERCENTAGE OF SAMPLING PERIODS) BETWEEN THE THERAPISTS' ROLE AS PROFESSIONALLY ACTIVE (A) AND EXPERIMENTALLY PASSIVE (P)

Direction of Verbal Social Behavior	*Clinic*	*Number of Periods*	*"A" Period*	*"P" Period*
With patients	Male	376	4.3	1.9
	Female	392	6.9	9.5
With occupational therapist	Male	376	7.0	5.0
	Female	392	5.4	3.3

TABLE III

explanation. One of the therapists in this study had already been in the study with chronic patients; it was her opinion that she had intuitively acted differently in the two situations. The spontaneity of acute patients apparently is sufficient to obviate the need for a large amount of specific supportive behavior on the part of the therapist. Also, the more demanding tasks in the acute clinics probably changed observant behavior on the part of the therapist to more active instruction and participation. In the acute group of patients rapport could be more naturally incorporated into occupational therapy tasks than could be required as a separate effort which seems necessary for the chronic patients (See Table I).

It was, of course, inevitable that the longer 50-minute clinics would bring out a little incidental, non-patient-directed activity by the therapist compared to its absence in the 15-minute sessions with the chronic patients. Noteworthy in both studies, however, is the fact that negative behavior (coercion, ridicule, etc.) occurred in only one instance out of almost 600 sampling periods.

The fact that a third of the occupational therapists' time with the acute group of patients (see Table I) was spent on routine activities, for example, answering telephone, keeping records, supplying material from cupboard, etc., raises the question concerning the economical use of the therapist's therapeutic skills. In the occupational therapy clinics a valuable part of the therapeutic situation is the interpersonal relationships between the therapist and her patients. If a third of the therapist's time is devoted to menial routine duties, then the interpersonal relationship suffers accordingly. To utilize and accentuate the therapeutic relationship between the therapist and her patients, it would seem likely that less skilled personnel, for example, volunteers or occupational therapy aides, might relieve the professionally trained therapist of a great many of these routine duties. This would permit the professional occupational therapists to contribute their needed share to the team of psychiatrists and others who work for the patients' recovery.

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Going to the Conference?

Have You Registered?

The annual conference is going to be an institute type conference patterned after the 1954 institute held in Washington, D.C. Group dynamics will be used all week and it is most vital that sufficient leaders be trained to adequately head the group discussions. The only available means of estimating the number of leaders needed for the conference is through advance registration. Therefore your cooperation is most necesasry in registering before you arrive in Cleveland. If you have not already sent in your advance registration card, do so today.

THE NEW LOOK IN INDUSTRIAL THERAPY

HELEN H. CHRISTRUP, O.T.R.*

Introduction. Industrial therapy has been developing gradually through the years. Its basic philosophy was founded on the age-old belief in the inherent benefit of work; its genesis was an outgrowth of the economic need prevalent in public psychiatric hospitals. Patient labor was essential to the operation and maintenance of these institutions, but with its continued use, the potential therapeutic applications became increasingly evident. Then, over two decades ago, Doctor William A. Bryan, superintendent of Worcester State Hospital, formulated the principles and practice of industrial therapy. Since that time, its growth has been rapid and it has adapted readily to changing concepts in psychiatry and to the increasing stress on rehabilitation. It is with these adaptations and changing concepts that this paper will be primarily concerned.

Purpose and scope. Industrial therapy, which has been considered primarily a treatment program, now serves the threefold purpose of treatment, rehabilitation and evaluation. These phases will be considered separately.

Treatment. The inherent therapeutic benefit of work is a concept which is today seriously questioned. Work, per se, is not a panacea nor even an anodyne.. Moreover, the smug acceptance of any activity as "therapy," once the label "constructive" has been attached, is subject to severe criticism. This is a subterfuge behind which inadequacy or ignorance all too often looms. Work, or constructive activity, may well be a therapeutic experience, but it is imperative that the patient be properly motivated, individually selected, continuously guided, and appropriately rewarded. These essentials are as applicable to occupational therapy in general as to the more limited scope of industrial therapy.

Motivation is a factor with which occupational therapists have always struggled. In many public psychiatric hospitals, however, its role has often been minimized because of the pressing needs of the industries. Certainly, until the public is willing to assume the tax burden commensurate with adequate financial support of their hospitals, the economic necessity for the utilization of patient labor cannot be ignored. Many therapists today effect a practical compromise. Whenever possible, placements are made which are therapeutic in nature. It is recognized however that assignments are sometimes made which are not necessarily therapeutic in the true sense of the word but which are beneficial to the hospital community of which the patient is a part. Care is always taken to insure that these will not be detrimental to the patient.

The basic ideas of work assignments as therapy have not changed. Assignments are selected which are consistent with the needs, abilities and interests of the patient and the therapy objectives as outlined by the physician. This presupposes a thorough knowledge of jobs available including the physical, mental and personality requirements for them. If a patient is placed in accord with these prerequisites, appropriate rewards are usually assured. Constant guidance is necessary to sustain continuous and progressive treatment.

Rehabilitation. It is realized there can be no strict delineation between the three phases we are discussing. They have been arbitrarily delineated here for the purposes of the discussion.

With the advent of the wide use of tranquilizing drugs in psychiatry, rehabilitation has received a new surge of urgency. Especially challenging are those patients who have been ill for many years and have recovered or improved. A long term program of rehabilitation has been found necessary for them. If an effective work and social adjustment within the hospital takes place, a gradual shift to the outside community may then be effected. In such cases, hospital work may provide the first step in the long road back and may represent to the patient the first concrete move toward return to the outside community. In the hospital, opportunity may be provided for reviewing old skills, learning new ones, developing good working habits and for increasing acceptance of responsibility. Ideally, work in the hospital, for rehabilitation purposes, should be graded but should be closely related to work outside the hospital. The standards for these jobs should be such as to meet requirements from private industry. The arrangement of work in the community, while the patient resides in the hospital, is a useful step as well as a fruitful resource not yet fully explored. Volunteer work or apprenticeships in the community may be a satisfactory solution where hospital or state regulations prohibit an employed person from residing in the hospital.

For shorter rehabilitation referrals, the same goals may be served, and actual job try-outs may be furnished within the hospital. Often, also, patients need to learn, perhaps for the first time,

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the self-esteem and satisfaction which may be derived from a job well done. They may learn this more readily within the protected environment of the hospital. It should be noted here that some patients are responsive to a work program who are not accessible through individual therapies. Work is an accepted and routine part of our daily life. When ill mentally, it may be more readily accepted than other reality situations.

The need for continued guidance must be stressed, particularly in reference to the rehabilitation phase. Guidance is a term used here advisedly; it is an active and a responsible function. Such functions as selection, guidance and evaluation are the responsibility of the therapist. If he is to have a dynamic and meaningful place in the medical team, he must be willing to assume this responsibility. It is his job to assist the patient in working out the problems relating to his assignment. Questions which arise concerning such things as, for example, the patient's future employment possibilities should be realistically discussed with him. As essential for the therapist as assuming his active role is, of course, being able to judge when these issues require referral to other members of the hospital staff. But to blandly refer all issues "to the doctor," as many of our schools teach us, is nothing but neglect of duty and an unreasonable burden on busy physicians.

Evaluation. Evaluation is a continuous process. In order for treatment to be appropriate and progressive, evaluation for changes in the therapy program must be made. Evaluations in regard to the suitability of the patient for a hospital work assignment, the effect on the patient of the assignment, and the patient's adjustment in his assignment have been an accepted part of the program. In this discussion, attention will be focused on a relatively newer type of evaluation the industrial therapist is called upon to make. As an outgrowth of the greater demand for rehabilitation resources, a real need has arisen. This is the need to evaluate the patient's readiness for gainful employment. This need is recently being met in functional occupational therapy through the use of some form of a physical capacities evaluation. This is certainly a useful and essential tool but, unfortunately, is not directly applicable to psychiatric occupational therapy. In psychiatry there are few short cuts. The most effective way of making such an evaluation appears to be in the actual placement of the patient in a job similar to that which he may be expected to perform upon discharge. A job sampling, however, is not adequate. The individual's present level of functioning must not only be such as to perform all the duties of the job and make the necessary adjustments in it, but he must be able to perform them at a consistent level over a period of time. There is no yardstick by which to measure this time. It has been observed that the length of time frequently increases positively with the length of hospitalization. As always, when dealing with human behavior, there are so many variables present that little of a less general nature can be said about this relationship.

Another important aspect of the evaluation phase is that of assisting in the evaluation of an individual's suitability or need for vocational rehabilitation. Patients are carefully selected for the OVR program. A hospital work assignment is an excellent tool to aid in assessing the patient's need for further assistance, his suitability for such assistance and his suitability for specific types of training.

Here again the responsibility for such evaluations rests with the therapist and must be assumed by him. No one else is in as strategic a position to make these appraisals. His evaluations and recommendations are, of course, based on the job performance and adjustment alone; it is the psychiatrist who assesses the complete picture and makes final recommendations and decisions based on the psychiatric condition, social adjustment and job adjustment of the patient.

Another way of considering the scope of an industrial therapy program is to consider the scope of the program within the hospitals. So extensive has been the expansion of the program into hospital-wide facilities that the term "industrial therapy" is now a misnomer. These expansions have spread from the hospital industries into the skilled shops, offices, research departments, fire departments, libraries, laboratories and adjunctive therapies. They have, in short, tapped every reasonable job resource available for patient rehabilitation. With such a program, the majority of patients can be placed in jobs directly related to those they may be expected to perform upon discharge. More accurate assessment of their capacity for employment is thus facilitated. Notable limitations of available resources within the hospital are jobs in the professional, managerial, and forestry families and many skilled groups.

Before concluding the present discussion a, word should be said about an old topic. It is imperative that regular reports, preferably written, be made to the physician. Not only must the physician be cognizant at all times of the patient's current assignment but he needs to know briefly the nature of the work, the demands and

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THE CHANGING ROLE OF OCCUPATIONAL AND RECREATIONAL THERAPY IN PRESENT-DAY PSYCHIATRY*

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Until recently when most persons would think of recreation, they would be inclined to regard it as comprising those activities in which they engaged after a busy working day for the purpose of amusing and diverting themselves; or, if they thought about it at all in conjunction with psychiatric patients, they usually conceived of it as comprising those functions and activities which helped the patient to successfully pass the time between his psychotherapeutic sessions with his physician. However, it can also have specific and curative effects on psychiatric patients and it is these particular effects and how they vary from patient to patient which I would like to discuss with you.

The specialized employment and utilization of recreation as a therapeutic tool is still a relatively new and largely misunderstood device in the treatment of the psychiatric patient both in and without the hospital. As is the case with most recent developments, it is not quite so new as we had at first thought. The use of recreation as a psychotherapeutic tool in the treatment of the patient has an interesting and largely neglected history. Dr. Hack Tuke, who is to my mind one of the most neglected of the psychiatric classicists and who, with Pinel, was perhaps the most significant psychiatrist of the early 19th Century, first wrote in 1848 on this subject. Dr. Tuke had noted at his private sanitarium, The York Retreat, an interesting and for that period a remarkable observation, namely, that psychiatric illness did not seem to so largely affect members of the artisan class. You recall that in England in those days there were few factories and most persons earned their livelihood at small specialized crafts which they pursued in their home with their wives and their children about them. It struck him as singular that these simple artisans who kept their hands and their minds busy making harnesses, carving wood panelling or doing stone work rarely had psychiatric illnesses, though he frequently encountered these in persons who had much leisure or who did what we would call today white collar work. As you know, there was a marked onus against physical labor in those days, and no one of the upper classes would engage in it because of the immense loss of status which this would involve. Consequently, when Tuke introduced simple craft work for all his patients regardless of their social origins, he had great difficulty in including the rich (and these were largely the persons who came to his sanitarium) to do tasks of this kind. This is probably the first general use, of which we have record, of what we would call today occupational therapy. And today it is difficult for us to appreciate or to understand the shock which such a policy engendered in the minds of laity and professionals alike. Only fifty years earlier Europe had been astounded to learn that King Louis XVI of France found it relaxing to employ as a hobby the trade of a locksmith which he had learned from a servant as a boy, and we read that he passed the long months in prison prior to his execution by repairing locks. Tuke, who discovered this, took this lesson to heart and despite the resistance of both his patients and the medical profession, organized a series of little craft shops in The York Retreat and was the first to describe the beneficial results which accrued to patients by work of this nature. He gradually came to learn, as we now know so well, that all work and activity in the hospital may have a therapeutic as well as an educational value for the persons who undertake it.

Tuke's observations, however, have revelance to a much large area than the use of recreation in hospital psychiatry, for indeed this problem of leisure is a most pressing and exigent problem today in all walks of life. Our own culture has changed in the past thirty years from one of economic depression and financial stringency to a culture of prosperity and leisure. For the first time men who had not been trained to use their spare time in intellectual or other pursuits have, because of the shortening of the work-week and the efficiencies produced by large-scale use of labor-saving machinery, large amounts of time on their hands; time which many of them do not know how to use profitably or pleasurably. This problem is particularly noted by psychi-

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atrists in those persons who are recently retired. One often sees patients who have devoted themselves to the pursuit of their chosen occupation for the twenty to forty years of their work-span. During this time the patient thinks of his work as being an immense hardship and looks forward eagerly to the day when he can retire and move to Florida and spend his days sunning, fishing and loafing. When the retirement day comes, however, he finds that far from its being the happy day of deliverance which he has anticipated, it is a day of evil omen for him. In a few short weeks he finds that these pursuits no longer divert him. He realizes, forcibly and painfully, that he is approaching the twilight of his life and he finds himself sitting around obsessed with anxious ruminations about his health. Every wheeze in his lung, every creak in his joint makes him think of the impending death which is now all the closer to him. After about three weeks of this he is in the psychiatrist's office and often he cannot understand why the fulfillment of the long anticipated goal is no fun for him. He has learned belatedly the lesson we must all learn, that recreation, like all aspects of mature and successful living is not a suddenly acquired skill, but one which requires practice, planning and foresight.

This inability to gain pleasure and relaxation through planned recreative play is not just a problem of the aged, but for all of us as well. Most of us have either too much or too little recreation, and there are few persons who strike a happy medium. Play can be a defense and operate as a full retreat from the responsibilities of life. But we are not so apt to see that, conversely, a life of *all* work and no play makes Jack not only a dull boy but an emotionally disturbed boy. This situation is more common than one might think. Consider our own situation. Most of us work long hours in our chosen occupation plus making additional time commitments in meetings, professional writing, research and other professional activities, not to mention time spent in the upkeep of our home, our car, shopping, commuting, and other demands of family life. These activities take up so much of our time that often we really have very little time in which to relax. When the time does come, we don't really know how to go about it or are too tired to gain pleasure therefrom.

The same situation is of course true for the person who has too much time. Try playing golf (unless you are a professional and make a business of it) for twelve to fourteen hours a day and do this the year around. Though golf may be your greatest pleasure, it will soon become loathsome to you. I recall a patient who was a professional baseball player and he once described very graphically his own change in feelings toward the game which had been his greatest pleasure as a youth and which had become his greatest anxiety when he was a man. Baseball, he said, was now a rat-race for him. Learning how to reduce tension through planned activity and play is a matter of concern, not only for the psychiatric patient, but for all of us.

Though we know that this is an area which merits our closest and most attentive study, yet this is difficult, for recreation is a word like honor, integrity or mother-love, words which Theodore Roosevelt aptly called "weasel words," because they suck all the meaning from words around them. They are like coins which go from hand to hand and are such common currency that the meaning has worn from them. Recreation is such a word. We use it in a facile manner, and because it is so easy to think that we know what we mean when we use it, there has never been any careful attempt to pursue a scientific study of this phenomenon.

It is for this reason that psychiatrists have only belatedly come to ask such questions as these, "What kind of recreation should be employed for what kind of patients?" "When should it begin in their therapeutic course?" "When is it contraindicated and what types are contraindicated for what patients?"

I thought we might find it profitable and interesting to discuss together some of the things psychiatrists now know specifically about recreation. It might interest you to know what kinds of thinking go through a psychiatrist's mind when he plans recommendations for therapeutic recreation for a patient, for there are now definite principles to be kept in mind when such recommendations are made.

But in order to make such a discussion meaningful, we must first have some common background regarding the concept of mental illness and how it is generated, particularly those forms of mental illness which are the product and result of learning experience. Let us digress then to briefly consider the antecedents of the disturbed state which we call mental illness.

There are, as you know, types of mental illness which are related to structural changes in the brain substance and to the anxiety and concern of loss of function attendant upon these. The majority of psychoses and neuroses, however, are called functional, and insofar as we can determine, these are not produced by any structural or by chemical change in the brain itself, but are instead the result of specific conflicts and defeats which we undergo in our personal, social and familial life. These conflicts operate as

traumata which affect the symbolic function and the capacity to apperceive and test reality.

For example, in studies of the antecedent family backgrounds of persons who suffer from psychotic and neurotic illnesses it is found that a large majority of them have lost parents by death, divorce, separation, or abandonment in their early years, or they have a history of severe rejection by their parents. They also have a long history of intense concern about their personal adequacy and merit, and manifest with a remarkable regularity a grossly impaired self-esteem. We handle these wounds in our psyche as we handle physical injuries by building up scar formation about them. These scars in our psyche take the form of defense mechanisms. We may attribute the blame of our self-hatred upon others, we may rationalize it, we may deny it, we may convert it to its opposite, or we may convert it to a physical somatic symptom. But the heavy artillery of defense, employed when the psyche has been severely shattered and when our defenses for coping with ourselves and our problems have been irrefragably breached, are what are called the psychoses. As you know, in this form of defense from experiencing intrapsychic pain, one gives up testing reality, and initially adopts a method of thinking which is called dereistic or unrealistic. In other words, the person so beset deserts this world which is so full of defeat, strain, horror and difficulty and creates a new world of his own analogous to the dream world, for our mind possesses the capacity to protect us from states of intense need and from the apperception of intense states of physical and mental pain. For example, all of us have had the experience of going to bed hungry or thirsty and having a wish dream in which we gratified the hunger or thirst. This can be an extremely vivid and intense experience. I once had occasion to interview a man who had crashed in the midst of a barren and arid desert. He was lost there for four days and almost died of thirst before he was rescued. He recounted that during the first day he was intensely, painfully thirsty and during the second day, weak, dispirited and frightened, and there was of course an intense and steadily mounting thirst. On the third day, however, he began to experience extremely vivid images (we would say hallucinations) of glasses of cool water which he could drink with a great and satisfying pleasure and it was only with difficulty after he was rescued that he could be induced to believe that he had not had the enjoyment of these hallucinated gratifications. In a similar fashion we know that there is a limit to our apperception of physical pain. Physical torture can only go so far. We can then repair to that little closet of our mind in which no one can hurt or harm us. It is well to remember in this connection that emotional, as well as physical torture, can force us to the same extreme of compensation. The mind develops ways to protect us from the realization of the experience of intense states of need.

What then are the emotional pains that can force one to so drastic a solution? Apropos of this we must remember that we are not born with the capacity to think rationally. We tend to take, however, our rationality for granted, as we do our table manners with its complex wielding of knife and fork, forgetting that we do this skillfully because of so many years of practice and experience. So it is true with the testing of external reality and with the conception of ourselves as persons, i.e., internal reality. These capacities are not wholly developed by rational forethought, but are instead absorbed by the magical, irrational acceptance of the opinions held towards us by the significant people in our environment, usually the parents. The child cannot initially reason for himself, and he is therefore prone to look upon his parents in a very similar way in which the religious adult looks upon God, namely, as an omniscient and omnipotent being. It is just for this reason, the child's inability to rationally appraise the parent and his attitudes, which makes for so severe a trauma and distress if the parent happens to be an intensely rejecting person, or if the parent has been lost by separation, death or abandonment. If the child could put it into words, he might say something like this, "If this being who is so wise, thinks that I am an evil and unlovable person, then it must be true and I must truly be these things." He then retains far into adult life, this conception of himself as a damaged, inadequate, worthless and evil person, and this situation also engenders, for obvious reasons, intense hostility and guilt. It is necessary to point out, of course, that the child does not put it in these words. These experiences occur very early in our life and the child does not verbalize them, since he has not developed the use of that complex symbolic tool which is language. The child cannot plan or hope and so reduce his anxiety in this fashion since this involves extrapolation from past experiences which is again a highly complex usage of symbolic function and which is not well developed in his early life.

This is the kind of background found in almost all persons who have severe and incapacitating neurotic and psychotic disorders. Of course the definitive help for this disorder is psychotherapy, but the specific ways in which this is done is not the subject of this meeting or our primary intent today, but rather what we can

learn about the role of recreation as a psychotherapeutic adjuvant in the treatment of patients, and how it can be attenuative and helpful to the kinds of anxieties and guilt feelings which we have just described.

With this background in mind we can understand how a psychotic or neurotic person whose illness has been so severe as to result in his hospitalization and isolation from his family and his culture, must feel in the initial phases of psychotherapy. For the most complex types of relationships we have in life are interpersonal relations and though we take them for granted because we engage in them with ease and facility, for the mental patient, these are extremely difficult and painful. These are the areas in which he has had the greatest failures and his most severe punishments and disappointments. Yet this, the most complex act we perform with people, must be reestablished if the patient is to communicate with his therapist and to achieve the insights and share the emotion which his cure will necessarily entail. But it is ironic and illogical to ask him to do the hardest thing first, not the simplest things, viz., to endure the pain and frustration of a tete-a-tete relationship. It is at this point that recreation and occupational therapy have their maximum application. For here we can patiently grade the patient's degree of interaction with others. We can supply him with an area in which he can have unlimited interaction with people or we can give him tasks which have goals which he is much more likely to be able to satisfactorily fulfill and which involve very little contact with others. And these goals in recreation and occupational therapy are symbolic of life's goal which has been too much for him, and which have led him to adopt withdrawal in an attempt to obtain a surcease from his pain.

In other words, one can tailor a program for the patient which will fulfill his needs; one can dose interpersonal contact, the most significant variable involved, according to the patient's capacity. For example, an extremely withdrawn catatonic who cannot be reached in psychotherapy (since this involves an interpersonal relationship which his past memory recalls to him as being frightening and guilt-inducing) can be set to work sometimes on a loom where he has little or no contact with people. He often derives a great comfort from this simple monotonous labor which yet gives him a task outside of himself and for which he can be legitimately rewarded. It restores his sense of accomplishment. There is simple wisdom in the old cliche, "Busy hands make for quiet minds." If we can interest the severely disturbed and pain-racked patient in even the simplest activities, we have accomplished a desirable result. Compare it with the child learning to walk. He must take a first halting step before he can hobble, and hobble before he can run. So such an activity is a first simple step towards the eventual goal of a full-time participant in interpersonal communication and response. We have also given him something creative and definitive which he can do, and with which we can help him. He is initially given a small task which he can achieve and this can then be increased to more complex ones. It may be a long time before the patient can graduate from the loom and to do a very simple piece of copper work or weaving a belt. And perhaps at a later time we can advance him to some kind of group project, such as group painting or play or the use of some plastic medium, such as clay or paint. And finally the patient is able to achieve the interrelationship of participating in simple group games. We must constantly bear in mind that these are tasks which are bound to be difficult for the patient in the beginning, and occupational therapy plays an indispensable role in helping patients to again have interrelationships with people which are not of a frightening and defeating character.

Thus we see that occupational therapy is not just something to keep patients happy and occupied while they are getting psychotherapy. It is also a specific and definitive area in which one can make a detailed description for dynamic reasons which can affect the patient as dramatically and as markedly as medication or psychotherapeutic insight. By use of chosen recreation and occupational therapy the patient is exposed gradually to the area of human contact and human endeavor, but the first competitive act he has to face is that of weaving a rug or making a billfold rather than having to work in a stockbroker's office or playing on a football field. He is, in other words, de-tensioned to the complex competitive strivings of every-day life by facing these in simple and graduated forms in the hospital. This is analogous to a kindly father teaching a child. If the father wants to teach his son to drive a tricycle and he wishes to instill a feeling of self-confidence in his son, he does not take him to the tricycle and say to his son, "Drive this; if you can do it expertly I shall reward you, if you do it badly you will never get another chance." Instead, he gives him simple graduated tasks of increasing complexity, is tolerant of his mistakes, and laudatory of his accomplishments. He suggests and helps him over the rough spots. This is analogous to what we try to do with patients in therapy, for they have regressed to a period in their life which is characteristic in many ways of that of a child, and

we must assign tasks analogous to the patient's stage along this regressive continuum.

We know that the second characteristic of the psychotic patient is that he has lost what we call affect or emotion. He cannot feel empathy or sympathy with others or even for himself. He has lost the capacity to put himself in the place of others, and to experience first hand the closeness to them which this entails. When this is lost there is little capacity to have warm gratifying, human relationships. And for the psychiatric patient this capacity to experience warm emotion is initially difficult, since he has been hurt in just these areas of human relationships. He obeys the ancient proverb, "The burned child shuns the fire." For this reason he tends to shun human interaction and emotion. He withdraws instead into a little cosmos of his own, free from emotion, feeling and dependency upon others.

These affects, too, are things which we can "ration" to the patient by recreation and occupational therapy. Remember the mass of emotion which we felt when we saw our first college football game, when with pounding hearts we would yell ourselves hoarse as we would watch the home team make the touchdown? Something analogous to this can be felt in the simple game of checkers, or identification with a team of fellow croquet players. These situations, simple and unexciting to us as they sound, have an important role to play in the psychiatric rehabilitation of patients. Here again one can give the patient symbolic goals which are nevertheless discreet and which can be graduated according to his ability to solve them.

Through activities such as these, patients can be helped to recover their sense of purpose and self-esteem which, without exception, is damaged in all psychiatric casualties. He may have concealed this damage from himself and others by being a braggart or compensated by a mechanism of reaction formation and formed a delusion of immense power such as thinking of himself as Christ or Napoleon. He may have withdrawn from others and from himself into a deep regressive wounded state. Or he may have protected his damaged sense of adequacy by the use of drugs as does the alcoholic, or the drug addict. The need to feel important, the need to feel that one's work has significance, the need to approve of one's self, and like one's self, even though we appreciate our disadvantages and demerits, is one of the constant goals of life and of psychiatric work. Recreation under a kindly helpful recreation director who lets the patient discover again the sense of personal worth and purpose which can be experienced in the achievement of a small task well and honestly done, performs a great service for his patient; he helps him to regain a very precious thing which he has lost, his self respect. There is also the additional advantage that the patient is at the same time practicing the use of the same kind of skills and attitudes which he will have to apply when he is to return to the real world and to the complex problems of a similar nature which he will encounter there.

The beauty about such use of recreation is that these therapeutic goals are not primarily identified as such. One does not say to the patient when you ask him to be shortstop on the baseball team, "I want you to contribute so that you can increase your skills by dealing with persons," you say instead, "Let's get on the team and we'll beat the other side." One is able to prescribe in effect a highly valuable therapeutic activity without identifying it as such to the patient. Similarly, after a pleasant afternoon on the golf range, or on an evening of bowling we ourselves come back not only with our skill in bowling and golf increased, but having also participated in a meaningful and gratifying human interaction which comprises the real purpose of the meeting; for it becomes silly when we say that we spend the entire afternoon for the purpose of knocking a little pellet from one grass hillock to another, or watching a black ball go down an alley to knock down some wooden pins. Moreover, we have expended in a socially acceptable form the hostility and competitive striving which could take other, and more dangerous, outlets.

The patient, therefore, has less anxiety in facing human beings when it is accomplished in these kinds of contacts. The technical word for this situation is "expectancy set." After a severe and regressive illness the expectancy set is less if you allow a patient to develop his first human contacts in recreation rather than his primary psychotherapeutic setting. And it is for this reason that most psychiatrists in dealing with this type of patient at this particular phase of his illness do not arrange to see him in the office, but instead first have a chat on the ward or on the playground.

We are also sometimes inclined to forget, too, that the everyday tasks which must be necessarily performed in the hospital can also be highly therapeutic and deserve to be considered under the general rubric of occupational therapy. It is hard for us to see how sweeping a hallway or mowing a lawn can be of therapeutic value to the patient, but experience has taught us that this is certainly the case. These tasks heighten the patient's sense of self-esteem by making him feel less guilty about being dependent upon the

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ADAPTATION OF HOMEMAKING SKILLS FOR THE HEMIPLEGIC WOMAN

RUTH EMMETT, O.T.R.*

In keeping with the newer concept of rehabilitation, the program for the hemiplegic housewife is directed towards her return to the role of homemaker. The occupational therapist need not wait for ideal accommodations within the hospital before initiating a retraining program.

The past five years of research with disabled housewives at the New York University-Bellevue Medical Center has revealed that hemiplegic women can return to the active role of homemakers or able assistants in the management of the home. The extent of rehabilitation depends upon the general physical health of the patient and her ability to master a few basic techniques. We are not concerned in this article with a return of function to the paralyzed hand.

Success in this program is dependent upon the homemaker's interest in her job prior to her disability. One can hardly expect the homemaker who has always disliked housework to tackle its many problems with much zest when new problems are added.

Primary skill in using one hand can best be developed in an unfamiliar medium. When the patient has had some success with a simple craft and training in basic activities of daily living, the time has come, with the doctor's approval, to introduce homemaking retraining. If fundamental skills can be practiced for short intervals while the patient is still in the hospital, the period of adjustment and frustration can be reduced considerably.

Here are the skills needed by the hemiplegic homemaker:

MEAL PREPARATION

Opening a can. A can of food can be opened with one hand with the wall-type can opener, using those models which have a lever for clamping the can. The patient is taught to open the clamp just enough to allow the rim of the can to be inserted. The can will then hang unsupported while clamp is being closed and handle turned for cutting. To remove can, the clamp is again only partially opened. To avoid the hazard of the can falling, the opener should be installed over a working surface.

Some patients prefer placing the opener at a level so the can can be braced between the hip and the opener during the clamping and unclamping procedure. Others with considerable manual dexterity can brace the can with the thumb while opening and closing the clamp lever with their middle or index finger. This opener can also be used on cans designed to be opened by a key.

Another recommended opener is the Edmond No. 30 which clamps onto a table edge and punctures the can by vertical pressure with one hand.

Cans with screw tops can be stabilized by placing the can in a partially opened drawer, and clamping it there by pressing the body against the drawer.

Breaking an egg with one hand. A "short order cook" nestles the egg in the palm of the hand, encircling it with the thumb, index and middle fingers, then with the hand in a pronated position and the wrist extended, he makes a cut in the egg shell by striking it on the edge of a bowl. Separation of the egg shell into halves is completed by a sidewise movement of the thumb and index finger. If the yolk is to be separated from the white, use one-half of the egg shell to scoop it out. The first attempts will probably result in broken yolks, but practice will correct this.

Stabilizing bowl and cooking utensils while stirring. Mixing bowls, with their own rubber suction cup base or bases designed to hold babies' dishes, can be purchased, and used with a variety of utensils. This is an excellent example of a gadget designed for one purpose which adapts itself readily to the needs of the disabled. Flat-bottomed utensils may be set on ribbed rubber mats.

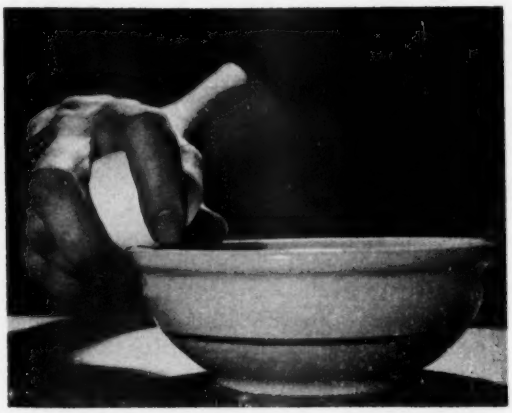
If lightweight skillets slide on the stove burners while stirring or turning the cooking food, the patient should revert to the well seasoned iron skillet. A stone or metal weight placed in the bottom part of a double boiler will help hold this utensil steady.

Lighting a gas burner with a match. Use a wooden kitchen match. Ignite the match and place it in a stable position on the burner before turning on the gas jet. If the design of the burner prevents this, try the following. Grasp the match in the fingers, turn on the gas jet, and quickly ignite the match by striking it on a rough position of the burner, lighting burner and match almost simultaneously. An ignited paper drinking straw helps light a low oven.

*Former director of home management clinic for disabled homemakers, department of physical medicine and rehabilitation, Bellevue hospital, New York, N.Y.

Breaking An Egg With One Hand

Step 1



Step 2

Step 3

Step 4

Operation of egg beater with one hand. Several types of one-hand egg beaters are on the market, most of which operate on a ratchet principle. A fork or hand-blender will do many beating jobs satisfactorily. Electric beaters can also be used.

Vegetable preparation. A cutting board with a short metal pin, such as a rust proof nail (or the end of an aluminum knitting needle) inserted from the back, will spear and hold vegetables for peeling. The patient should be instructed to keep the blade of the paring knife as flat as possible against the object being peeled and not perpendicular to it. She should also be taught to grasp the knife handle near the blade, leaving the thumb free to stabilize the vegetable. She may also use a rotary-blade type of peeler.

Onion skins can be best removed by the fingers, after the onion has been cut into sections.

Slicing vegetables can be done while they are still impaled on the metal pin, and then chopped, if desired, on the cutting board. A French-type cutting knife is most effective for chopping food on the board, and should be used by keeping the point of the knife on the board, cutting with a lever-type motion.

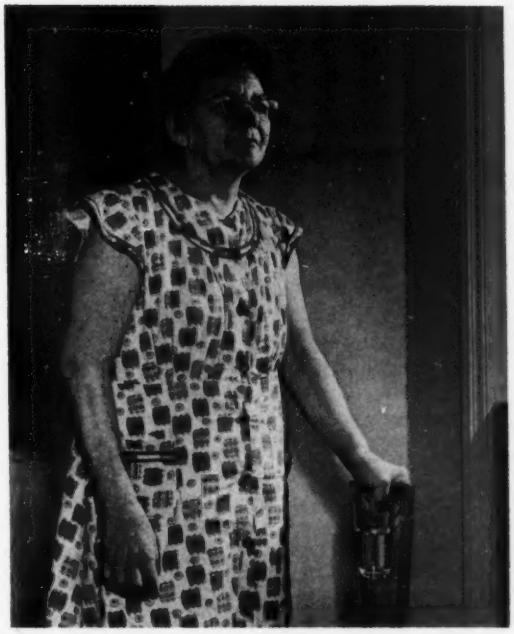
Grating can be done with the old fashioned four-sided grater. It should be used on its side with the bottom end braced.

There is also on the market a combination vegetable-slicer and grater which, when braced, can be used easily with one hand. It is adjustable for varied slicing thicknesses.

Squeezing citrus friuts. Place hand squeezer on a rubber kitchen mat to prevent slipping.

Draining foods. Vegetables cooked in a small amount of water in a one handled saucepan do not present the problem to the hemiplegic that draining spaghetti does. This is accomplished once again by a half-cover, perforated for draining off fluids, and held securely in place by a spring hooking device. This cover is clamped in place when the saucepan is cold.

Many foods can be removed from the cooking water with a strainer spoon or kitchen tongs,



Setting the Table Before Retraining

thus delaying a trip to the sink until the water has cooled, and can be emptied safely.

Use of the rolling pin. Specially designed one-hand rolling pins are unnecessary. Place the rolling pin in the center of the prepared pastry dough in the customary manner. Place the palm of the hand lightly on the center of the pin with fingers extended, and rotate the pin. When ready to transfer the rolled pastry to the baking dish, place the rolling pin near one edge of the pastry. Pick up the edge and roll it lightly around the pin until the center of the pastry is reached, then grasp one handle of the pin, extend the index finger on the pin to keep it from rotating, and carefully lift the pastry. When the pastry is in position over the baking dish, unroll the pastry on the tin controlling the speed with the extended index finger. An asset for any homemaker is a floured piece of white canvas on the table surface, and white cotton stockinette material slipped over the rolling pin.

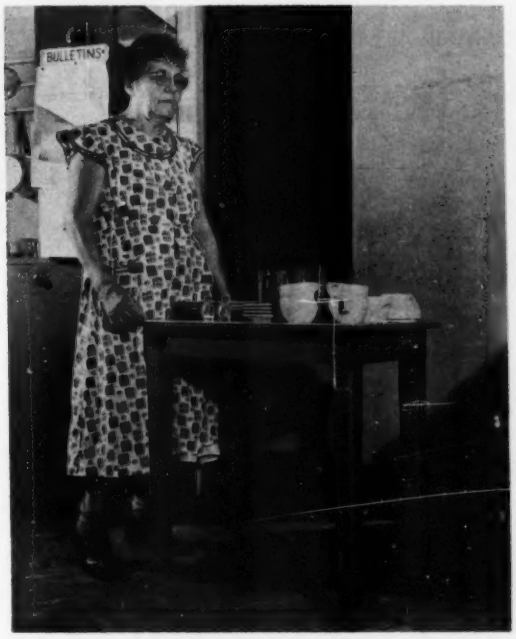
Moist ceramic clay makes a suitable substitute for practice sessions with pastry and rolling pin in an occupational therapy shop.

Use of a pressure cooker. Manipulation of the ordinary pressure cooker is difficult and unsafe for the hemiplegic housewife. However, there is on the market a completely automatic pressure cooker provided with its own electric hot plate, time device and pressure gauge. The pressure is released without the necessity of carrying the hot filled cooker to the sink for cooling. The close supervision required of other cookers is no longer necessary.

Shaping meat patties. A tuna fish type of shallow tin can with both ends completely removed makes a mold into which ground meat can easily be pressed with one hand.

MEAL SERVICE

Setting the table. Many hemiplegics walk with a cane, or need their normal hand for support in some manner. Therefore, transportation of hot casseroles involved in table service becomes an endless chain of hazardous trips from cupboard to table. A wheel-table can be substituted for



Steeing the Table After Rehabilitation

the cane. The articles to be carried are then placed on the table and pushed in front of the homemaker as she walks. The same wheel-table will serve many roles aside from meal service. It makes a portable work surface, and a stand-by to assist in laundry activities. Wheel-tables are available in a wide range of prices and types, and can be made by the family handyman.

A small shelf or storage cabinet, within reach of the dining table, should hold paper napkins, catsup, extra silver ware, sugar bowl, etc. These are the items which are easily overlooked in setting the table and provision for their "in-between" meal storage at the point of use will save many steps in the course of a day's work.

Clean up. After the meal, left over food and soiled dishes are returned to the kitchen via the wheel-table, where the hemiplegic housekeeper is confronted with a new set of problems.

Wringing the dish cloth. The hemiplegic homemaker will find that sponges are compact and easily squeezed with the fingers. Two or three of these damp sponges located in strategic points about the kitchen often save trips to the sink to wash the hand. Wringing small articles such as dish towels is described under "laundry procedure."

Washing the inside of glasses. We normally hold a glass in one hand while we wash the inside with the other, therefore some device must be substituted for the secondary hand. The answer is found in a bottle type of brush which will attach to the side of the sink by means of a suction cup. The brush is inserted into the drinking glass and the glass is rotated until it is clean. Such a device is seen at soda fountains. A woman using her left hand will find it most convenient to have the brush on the right side and vice versa.

Scouring pots and pans. Put them to soak immediately in warm sudsy water. Fifteen or twenty minutes will usually soften the food sufficiently to wash off without scouring. Should scouring still be necessary, a rubber mat in the bottom of the sink will help to stabilize the utensil during the process.

The number of dishes to be washed may be reduced by cooking two or more foods in the same kettle at the same time. Wrapping each food separately in aluminum foil saves burner space and fuel. Casserole meals save dishes and can be prepared on top of the stove in a small baker or ovenette if the housewife is unable to use the low oven which is still found in most homes.

Drying dishes. If the housewife feels that she must wipe her dishes, have her sit down to do it. A plastic apron covered with absorbent toweling provides a good lap working surface.

LAUNDRY

Interviews with the hemiplegic housewives at Bellevue Hospital reveal little need for heavy laundry work. In the case of personal laundry, careful consideration of laundry requirements of an article at the time of purchase will save considerable time and energy. Nylon, seersucker, plisse, and cotton knit goods require no ironing. The washing of household linens can be greatly reduced by the use of place mats which are easily wiped clean. Tablecloths protected with transparent plastic covers and the use of paper napkins also save laundry. Style of clothing should be considered from the point of use and ease in dressing.

Assuming that the hemiplegic housewife has reduced her laundry duties to a minimum, the following suggestions and practices will prove helpful.

Washing. Soak the laundry in warm water and suds so that soil is loosened and more easily removed. For very soiled spots that must be rubbed, use a small hand wash board. Either use a small-size old fashioned corrugated one, or the modern plastic version which can be strapped to the paralyzed hand.

Wringing clothes by hand, especially larger pieces, can be accomplished in a satisfactory manner by looping the garment around a faucet, grasping both ends in one hand and extracting the moisture by a combined twisting and pulling motion. Smaller articles of rayon and nylon are dried by rolling in a turkish towel and giving a few kneading motions.

Ironing. Ironing clothes with one hand, at best, is not easy. However, these few suggestions will make it somewhat less fatiguing and frustrating.

If an adjustable ironing board is not available, a low table with a folded sheet for padding can be used so ironing can be done sitting down. Use a comfortable chair with back support and have the feet flat on the floor or on a foot stool. Poor posture causes early fatigue.

Using a slightly cooler iron than formerly will allow one to use the iron as a weight on the fabric without danger of scorching, while smoothing out wrinkles with the hand.

A cord tender or device to prevent the ironing cord from dragging across the board prevents extra wrinkles.

Equipment should be arranged so that articles prepared for ironing and finished garments can be picked up and disposed of without getting up from the ironing board.

GENERAL HOUSEWORK

Bed making. Fitted bottom sheets simplify the daily bed making task, and may be made from regular sheets. Instead of spreading the bedding in the usual manner, the folded sheet should be placed on one corner of the mattress in such a position that it can be opened, one section at a time, allowing it to fall into place.

Light cleaning. Heavy cleaning is usually medically contraindicated for the hemiplegic. Some mopping can be done with a lightweight sponge mop. Models come with a separate perforated metal shelf which attaches to the inside of the cleaning pail. The excess water is extracted by placing the sponge on the inside rack and exerting pressure downward on the mop handle.

A long handled dust pan and short handled broom, such as are used in theatres and hotel lobbys make brushing up easier. Be sure to

select a dust pan whose handle will remain in an upright position independently. Large loops attached to handles of brooms, dust mops, etc., at a convenient height for the worker may allow her more freedom in activity without dropping the handle. In some cases she may be able to slip a flaccid arm through the loop and thus promote some shoulder motion in the paralyzed side as she does her cleaning.

Aprons with large pockets provide a means of carrying dust cloths and small articles during the process of cleaning. Aprons made with a narrow strip of spring hardened steel inserted in the waist band, clip around the wearer's waist, and eliminate the problem of tying apron strings. Aprons also may be made with an elastic waist band.

HOME SEWING

It is probable that the hemiplegic woman with no previous interest or ability in home sewing, will not attempt to sew following her disability. However, we have found a sufficient number of homemakers who did wish to resume simple home sewing, to justify a consideration of their special problems. Sewing should be introduced late in the retraining program in order to avoid frustration and discouragement.

The following suggestions have proved helpful:

Working on a rug or nappy surface reduces slipping while cutting, pinning and sewing.

Use paper weights to hold pieces in place.

When inserting a common pin, hold it between the thumb and middle finger with the index finger resting on the pin head, ready to stab it in vertically, and then turn to a horizontal position. Scotch tape can be substituted for pins in some places.

Use a yardstick or wooden ruler to check grain of material, instead of a tape measure.

Thread a needle by setting it upright in a pin cushion or upholstered arm of a chair.

For hand sewing, thumb tack or pin one end of the material to a suitable surface, and fasten the other end in the lap with a sand bag or other weight. Experimentation with each person will determine the best height, distance and tension for that individual. Some women prefer to wrap the material around a heavy folded newspaper to produce the needed tension.

For sure control of the direction of the material under the sewing machine needle while using only one hand, it is often necessary to keep the fingers nearer the needle than when using two hands, therefore a safety guard is a wise precaution.

A seam gauge attached to the sewing machine will assist in making uniform seams. If the sewer stops for frequent adjustments, she will soon be able to control her sewing as well as she did formerly.

A little practice under a therapist's supervision will develop a satisfactory method of threading the sewing machine and winding a bobbin with one hand.

Have the rheostat checked on the electric sewing machine to insure maximum control over the rate of speed of the stitching.

SAFETY IN THE HOME

All homemakers should be aware of the potential hazards in the home. It is the therapist's responsibility to emphasize their importance in terms of the housewife dependent upon one hand, and decreased locomotion.

Observe the following safety rules:

Light the match before turning on the gas jet.

Keep handles of cooking utensils turned away from the line of traffic to avoid "spills."

Keep a box of baking soda or a small one-hand-operated fire extinguisher near the stove in case of grease fires. Even a large cover can be used to smother flames.

Wipe up spills immediately.

If necessary to use any, use the self-polishing type of floor wax.

Watch out for toys, etc., in the path of travel and avoid small rugs.

Avoid the use of long electrical extension cords. However, if these are necessary, keep the excess cord coiled up, or better still, rearrange appliances.

Turn on lights in dark rooms before entering, or getting out of bed at night.

A small night light is a good idea.

A secure and adequate hand hold or grab rope over the bath tub or shower is important.

Do not climb. Even step-stools are dangerous. Rearrange storage to eliminate the need for climbing.

Sharp knives are safer than dull ones and should be stored separately.

Use a pin (as described previously) in a cutting board to stabilize food while being cut.

Allow plenty of time for any job, to avoid haste and confusion.

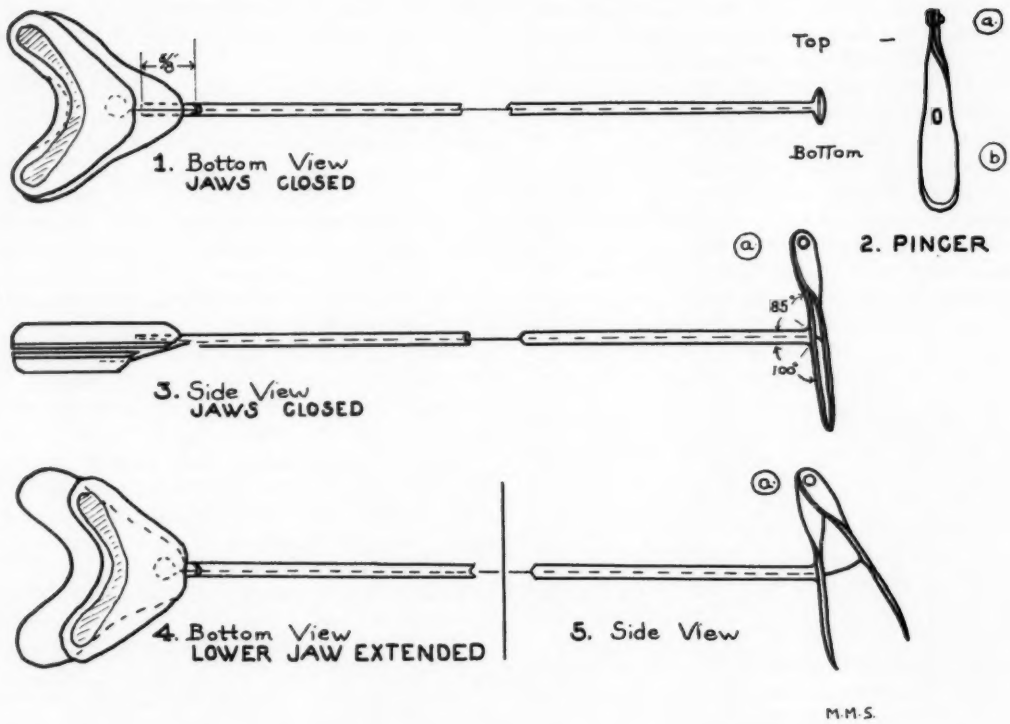
Take frequent short rest periods to prevent fatigue instead of one long rest when exhausted.

In conclusion, the hemiplegic should be encouraged to use the paralyzed hand and arm as an assisting hand whenever feasible, but not to the point of tension, fatigue and frustration. Short practice periods under a therapist's supervision will minimize these effects. When the basic method is learned and understood, practice at home will improve dexterity.

It is estimated that there are 650,000 hemi-

(Continued on page 290)

THE PINCER MOUTHSTICK*



The pincer mouthstick is an orthesis[1] designed for the placement of paper in typing and for the manipulation of playing cards. This is used chiefly by the individual with gross limitations of reach, grasp and fingering. The necessary precision of construction is justified by the end result. The number of independent activities that can be performed by an individual with extensive upper extremity paralysis is so limited that the inclusion of one or two otherwise insignificant tasks offers tremendous satisfaction to the patient.

This mouthstick has been developed in an effort to create an inexpensive reacher operated by jaw motion and action of the neck muscles. Mild alteration of the self-curing acrylic method[2] of making the mouthpiece led to the development of a split layer or sliding mouthpiece. The action of the mouthpiece is relayed down the shaft by spring wire activating the pincer blades. The tubular shaft affords the casing for this wire. Minimal weight is essential and the final results have produced an orthesis weighing approximately one ounce. Appearance is neat and inconspicuous.

DIRECTIONS

Materials

Two pieces of one-sixteenth Plexiglas two inches by two inches[2]

Self-curing acrylic (monomer and polymer)

Two pieces one-thirty-second inch Z-nickel three-eighth inch by two inches

One Monel rivet one-sixteenth inch

One piece approximately eighteen inches stainless steel tube O.D. one-eighth inch.

One piece piano wire .018 gauge two inches longer than selected length of tube

Lead solder, acid core (Kester) one-eighth inch

Silver solder (Easy Flow) three-thirty-seconds inch.

Construction

1. Shaft

(a) Cut the length of stainless steel tubing approximately eighteen inches or longer if needed to provide easy reach to the back of the typewriter.

(b) Cut one length of .018 gauge piano wire, two inches longer than the steel tube.

*Submitted by the occupational therapy department and research brace shops of the Georgia Warm Springs Foundation.

2. Pincer Blades

(a) Cut two pieces of one-thirty-second inch gauge Z-nickel, three-eighths inch wide and two inches long.

(b) In these drill holes for Monel rivet at (a) in figure 2. Join both pincer blades with rivet.

(c) Grind the blades from the midpoint for a distance of one inch tapering the width to one-fourth inch at the hinged end.

(d) Twist this half of the blade through 90 degrees (see figure 2).

(e) Arch the free ends of the blades inward slightly and bevel the outer edges. Line the inner surfaces with sandpaper, moleskin, or tape if a stronger grip is necessary.

3. Joining shaft to pincer

(a) Drill a hole large enough to accommodate the steel tube in the proximal blade of the pincer at the midpoint of the blade.

(b) Drill a fine hole in the distal blade of the pincer to accommodate the piano wire. This hole is slightly off the center of the hole on the other blade toward the open end of the blade.

(c) Using silver solder, attach the tubing to the pincer, (see the angles on figure 3). After soldering, ream out the hole to one-sixteenth inch to allow clear passage for the piano wire.

(d) Grind the opposite end of the steel tubing (mouthpiece end) until the hole of the tubing shows. This ground area is approximately five-eighths inch long. Flatten this ground area, leaving it rough to promote union with the plastic of the mouthpiece.

(e) Draw the piano wire through the tube, passing through both blades of the pincer. Bend the tip of the wire, and solder into place with lead solder.

4. Mouthpiece

The mouthpiece is constructed with acrylic plastic based upon the two squares of Plexiglas.[2] The major difference in construction of this mouthpiece is that the upper and lower impressions are made separately upon their own portion of Plexiglas. This provides a smooth surface for the gliding action of the orthesis.

(a) Place a roll of acrylic material in bite-shape on a smooth square of Plexiglas and take an impression of the upper teeth. Repeat this for the lower impression.[3]

(b) Grind both of these impressions down radically, both within the bite and surrounding the bite on the inner arc. This material shrinks slightly and the fit of the bite should be loose to allow for easy removal of the mouthpiece from the mouth. Projections of the flat plastic must be left at the front of the bite to allow for a secure joint to the shaft. Leave one inch on the upper impression and one-fourth inch on the lower.

(c) By means of additional acrylic, fasten the flattened tip of the tube to the upper surface of the projecting Plexiglas of the upper impression. Grind a groove on the under surface of the projection to allow the wire to move smoothly over this surface as it leaves the tube and inserts into the lower impression.

(d) Hold both portions of the mouthpiece in place and measure the amount of excursion of the lower jaw. Cut the wire from the shaft to equal this but allow sufficient extra length to loop the tip of the wire for anchorage. Jaw excursion varies and can be as much as one-half inch. Check the effect this distance has on the opening of the pincer blades, allowing for as much as three-fourths inch if possible.

(e) Secure the looped end of the wire to the lower impression with additional acrylic.

(f) Grind these latter two areas as neatly as possible without jeopardizing the strength of the union.

This orthesis was originally developed by Miss May E. Chin, O.T.R., with the assistance of Mr. Francis Jones, C.O., and Mr. George Chapman, orthetist. Miss Margaret Simpson, O.T.R., continued the development and assisted in the preparation of this presentation, coordinated by Miss Muriel F. Driver, O.T.R.

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"The word 'orthesis' may be defined as a medically prescribed device, applied to or around a weakened bodily segment to give support and increased function."
2. Sniderman, Marvin, D.D.S., and Lucy Irene Hollis, O.T.R. "The Use of Self-Curing Acrylic in the Making of Mouthpieces," *The American Journal of Occupational Therapy*, VIII:3, May-June, 1954. Details of construction are clearly defined and recommended for assistance in construction of the pincer mouthpiece.
3. Impressions should be taken by a dentist to avoid any complications.

New York University is offering a course entitled "Upper Extremity Prosthetics" October 28 to November 9, 1957, and June 9 to 20, 1958. Another course entitled "Upper-Knee Prosthetics" will be offered from December 9 to 20, 1957, January 20 to 31, February 24 to March 7 and April 28 to May 9, 1958.

These two-week courses are open to graduate occupational therapists and tuition fee is $125 per course. A limited number of scholarships are available.

For further information write:

Prosthetics Education Program
New York University Post-Graduate Medical School
550 First Avenue
New York 16, New York.

A SIMPLE PLASTIC MOUTHPIECE

JEROME D. STEIN, JR., Ph.D.*

Untrimmed Hose

Bushing Inserted

Trimmed to Shape

Shaped Over Bushing

There have been certain patient objections to the commercial mouthpieces available for the administration of positive pressure as a respiratory aid. One brand, of rubber or neoprene over a steel insert, results in a deposit of black rubber-like material on the lips and in the mouth and has an uncomfortable "feel" or "bite" because of the steel insert. Mouthpieces made of acrylic plastic are expensive and easily broken. There is a tendency to bite too hard, the material cracks and is soon impossible to use. Another type is fabricated of nylon, and although pleasing in texture, is too large and awkward for many patients. This article attempts to describe the manner of making acceptable mouthpieces at little cost and effort.

The material used is garden hose of thermoplastic polyvinyl, one-half inch inside diameter. The thinner the hose wall, and less expensive the material, the more satisfactory it is. A four inch length of hose is placed in an oven at 110-120° for ten to fifteen minutes to soften. It is then removed, using a rag or pair of cotton gloves to protect the hands, and trimmed with ordinary scissors. Trimming while soft results in a smooth, finished appearance to the product. The trimming of the mouth end should be done so that there will be an angle of about 55°. This can be varied to conform with the patient's occlusion. The piece of tubing should now be returned to the oven for reheating.

While the tubing is heating, a stainless steel bushing from a commercial mouthpiece is prepared by coating it with a lubricant. Glycerin or a silicone grease is satisfactory. The reheated tubing is now removed from the oven and the bushing forced into the mouth end, and with the fingers the flange is formed by pulling back the trimmed lips. While holding these lips back, a bend is formed in the tubing just behind the bushing. The entire unit, held in shape by the fingers is now immersed in cold water to fix the shape. When cold the bushing can be removed, and the mouthpiece will retain its shape.

*Senior research associate, division of physiology and pharmacology, Ortho Research Foundation, Raritan, New Jersey. Article prepared while research associate at the Poliomyelitis Respiratory and Rehabilitation Center, Fairmount Hospital of Alameda County, San Leandro, California.

Home Making Skills . . .

(Continued from page 287)

plegic women in the United States. Not all may be housewives in a literal sense, but most women have household activities to perform. Need of help by this group is increasing, due to the greater proportion of survival than formerly, the lengthening of the life expectancy of the population in general, and the newer concepts of rehabilitation.

The hemiplegic housewife is no longer necessarily doomed to a passive existence in a chair by the window where she easily becomes a burden to those she formerly served. The final outcome rests with the patient herself, and with those who have the skill, patience, and "know-how" to teach her to live with her disability.

BASIC EQUIPMENT

Most occupational therapy shops have a sink with running water and this area makes a logical focal point for the retraining program. Near it may be the following:

Roll of wax paper
Paper drinking straws
Empty coffee can to make a potato baker for top of stove
Wall type can opener ("Daisy," "Swing Away," or "Can-O-Mat")
Empty cans of assorted sizes and types for practice
One hand flour sifter

One hand egg beater
Evaporated milk can opener for use with one hand. (This device can be obtained from the Pet Milk Company with a label from a can of their product)
Paring knife
French knife for chopping
Wood cutting board with a rust proof nail in the center for holding the vegetable in place for peeling
Vegetable grater and slicer*
Place settings for table (dishes, silverware, etc.)
Soap powder or detergent for washing dishes; tea towels to be used in drying dishes, practice washing and ironing techniques
Small hand wash board
Ironing board or pad for table which can be used comfortably while sitting
Cord tender for ironing board
Electric iron, preferably light weight
Simple cotton blouse for ironing practice
Small rubber pad or mat to prevent slipping
Grip-tite bowl or other suction cup base for anchoring bowls*
Sparkleen glass washer*
Cellulose sponge
Long handled sponge mop and pail with perforated inside shelf
Lemon squeezer—cheapest hand type
Two quart sauce pan*
One-hand drainer lid to use with saucepan*
Long handled dust pan*

Arrange for use of a hospital bed when needed for practice in bed making.

*A scrap book with illustrations of one hand equipment may be used when the articles are not available for actual use and demonstration.

FOOD OR SUBSTITUTES

The following foods or food substitutes can be used for demonstration and practice:

Potatoes
Onions
Carrots
Sugar
Preem (a dry cream substitute which requires no refrigeration and is used for that reason)
Instant tea and coffee
Moist ceramic clay
Egg shells (carefully broken in half, cleaned and with halves hinged with Scotch tape)

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Industrial Therapy . . .

(Continued from page 277)

requirements of the job, the patient's behavior, the nature of his relationships with other people, the patient's own attitude toward his assignment and an overall evaluation of the patient's present level of performance. Any changes in assignment, together with reasons for these changes should be reported immediately.

Criticism. Although many criticisms regarding methodology could undoubtedly be raised, these are usually circumstantial. The really fundamental criticism is that of the lack of validation of the basic assumptions of the program. We assume, for example, that the majority of patients are benefited by participation in such a program. *But we do not know this.* Similarly, we assume that a good job adjustment in the hospital is indicative of a good job adjustment outside the hospital. There is a keen need for research in the field of occupational therapy in general. Industrial therapy lends itself admirably to such research (much of which may have wide application), as tangible tools of measurement are available. The duration of employment and performance ratings by supervisors, for example, are generally accepted indices of job success. Comparisons could thus be made between job success prior to hospitalization, and after discharge for patients who have and have not participated in an industrial therapy program. Relationships of these adjustments to age, diagnosis, intelligence, job families, and so on could readily be made from available records.

Summary. Once primarily a treatment program, industrial therapy now serves the threefold purpose of treatment, rehabilitation and evaluation. Treatment, in the true sense of the word, can only take place when the patient is individually selected, properly motivated, continuously guided and appropriately rewarded. These essentials are the responsibility of the therapist. For rehabilitation purposes, job assignments within the hospital may provide an opportunity for an actual job try-out, for reviewing old skills, for learning new skills and for gaining self-esteem from a successful job experience. Evaluation aids in determining a patient's readiness for gainful employment, determining his suitability for vocational rehabilitation assistance; assessing his present level of performance; and assuring continuous and progressive treatment. Regular reports to the physician are necessary.

An industrial therapy program presents a rich field for fruitful and much needed research.

*I wish to extend appreciation to Margaret Danley, O.T.R., who assisted in preparation of this article.

NATIONALLY SPEAKING

From the President

The past year has been an interesting one for the American Occupational Therapy Association as an organization and in terms of its members. The most significant undertaking in the areas of individual and group professional development is, of course, the institute-conference to be held in Cleveland, October 21-25, 1957. All of us are aware of its purpose and plan, and the reason for such a program. Those of us who participate will, I am firmly convinced, go home better qualified for our jobs because, inevitably, our understanding of our professional responsibility will have been objectively broadened while our understanding of ourselves and our role will have been discerningly clarified. There is nothing quite as helpful as group discussion to sharpen perspective and refine thinking.

Second in significance, only because the number of participants was limited, is the workshop conference, "The Psychiatric Occupational Therapist, Function and Preparation," often referred to as the Allenberry psychiatric conference. Mrs. Gail S. Fidler, O.T.R., the coordinator, reported to us on this project in the March-April, 1957, issue of AJOT. If you have not read her column in Nationally Speaking, please do. You owe it to yourself and your profession.

It is a recommendation made by the participants in this conference to the Board of Management of our association, and the steps taken to implement it, that I propose to discuss. The recommendation reads:

> "We, the participants of the Allenberry psychiatric workshop conference, present the following recommendations to the Board of Management of the American Occupational Therapy Association:
>
> That they initiate a study directed toward increased unity and integration of activities treatments and programs by extending an invitation as soon as feasible to the official organizations representing the activity treatment disciplines to join with the A.O.T.A. in:
>
> a. Meeting to discuss the implementation of this objective.
>
> b. Making a study of desirable and mutually acceptable patterns of integration on both clinical and educational levels, including the consideration of our own common, and/or unique problems.
>
> c. Mutually determining the advisability of seeking a grant of funds under the joint auspices of the above organizations to facilitate this study."

This recommendation is worthy of your careful consideration. It was made by a group which, although predominantly composed of occupational therapists, was truly diversified. It was made after a week of group thought and repeated recognition of the need for closer correlation between the activity disciplines that contribute to the care of the psychiatric patient. Finally, this recommendation parallels one made by our association to the Joint Commission on Mental Health well prior to the time of the Allenberry meeting.

At mid-year, on the basis of the recommendation, the Board of Management voted to invite organizations whose members contribute to the care of the psychiatric patient through the medium of activities, to send representatives to a meeting to be held in our national office. The purpose of the meeting to be to effect closer integration of patient service through increased mutual understanding.

The response to the invitation was most gratifying and served to further validate the recommendation made at Allenberry. It also pointed up the appreciation of the need for such a meeting by those concerned. All organizations invited to participate were represented at the meeting held on June 7, 1957.

The representatives and their organizations were Miss Lucy Fairbank, Council for the Advancement of Hospital Recreation; Mr. Earl Frost, section on educational therapy, American Association for Rehabilitation Therapy; Mr. Joseph McQueen, section on manual arts therapy, American Association for Rehabilitation Therapy; Mrs. Zetta Putter, group work section, National Association of Social Workers; Miss Martha Stovall, Association of Hospital and Institution Libraries, American Library Association; Mr. Robert F. Unkefer, National Association for Music Therapy; and Mrs. Gail S. Fidler, O.T.R., American Occupational Therapy Association. Dr. Donald M. Carmichael, a member of the executive committee of the Allenberry project, served as consultant and representative of the American Psychiatric Association. As president of our organization, it was my good fortune and privilege to represent you as host and to moderate the meeting.

The June 7 meeting proved to be an excellent beginning on the path to patient-oriented, increased mutual understanding. The group, as all groups do, had to go through a period of adjustment. However, it was surprisingly brief. Perhaps this was because three participants from the Allenberry conference were present. More probably it was the recognition of the vitality and immediacy of the topic in relation to each of the activity areas represented. By the time the meeting adjourned, it had been determined that the group would meet again for further de-

liberation before making any recommendations. A tentative agenda had also been planned.

The second meeting was held on July 20 and 21, again at our national office. All representatives save one were present. By the afternoon of the second day the members of the group were in unanimous accord and had drawn up the report to be submitted to their respective organizations for formal action. In addition, they had chosen a name, "The Interdisciplinary Study Group"; had determined that the group would maintain its identity until final action had been taken on the report; had chosen Miss Lucy Fairbank as secretary and had scheduled a meeting for next November 10 and 11.

The basic recommendation in the report of the Interdisciplinary Study Group is that "a permanent interdisciplinary council of organizations be formed for the purpose of providing maximum benefits to patients through coordination of the efforts of those disciplines using activities in the therapeutic care and treatment of the mentally ill . . . each member discipline to have equal representation on the council."

It was an exciting professional experience to work with this group. The prime considerations were improved patient treatment and the effect poorly coordinated activity programs have on patient treatment. The report is a challenge to all activity disciplines and is the beginning of the implementation of the recommendation made at the Allenberry conference.

The report will be presented to the Board of Management at the annual conference. The action taken will be reported to you at a later date.

Ruth A. Robinson
Lieutenant Colonel, AMSC
President

From the Executive Director

An intensified recruitment drive for occupational therapy students has been made possible by a March of Dimes grant of $29,971 effective July 1. The new grant brings to $103,050 the amount of March of Dimes support of the American Occupational Therapy Association since 1948. During the past years, this is what has made possible the expanded public relations program, the vital phase of which has been recruitment.

The shortage of occupational therapists nationwide makes it imperative that young men and women be recruited in far greater numbers than at present. The current enrollment of students in training is 2289, which does not represent full capacity in the schools. Within the last five years all of the schools have increased tuition, which presents one of the difficulties of recruitment.

In addition to continuing its vigorous public information program, AOTA intends to develop new recruitment kits for nationwide distribution. Much of the new material will emphasize the role of the occupational therapist in the treatment and rehabilitation of victims of poliomyelitis. The June AJOT, which was the special issue on poliomyelitis, indicated the increasing contribution of occupational therapy.

In awarding the grant, Mr. Basil O'Connor, president of the National Foundation for Infantile Paralysis, noted that support to AOTA is a basic part of the National Foundation's professional education program. He added, "It is certainly clear that polio patients cannot receive the high level care they need unless there are sufficient numbers of qualified professional personnel. The occupational therapist is a key member of the team of professionals needed by the polio patient."

The grant to the American Occupational Therapy Association is part of the March of Dimes program supporting professional education. Since 1938, over $26,500,000 has been distributed by the National Foundation to assist in recruitment and training of research, medical and associate medical personnel; and to help improve professional standards and services in the health fields. The published reports of the national recruitment committee and of the division of public information vividly describe the activities which have been made possible through this generous contribution of the March of Dimes.

The American Occupational Therapy Association is appreciative of the support extended by the National Foundation for Infantile Paralysis. Only an effective recruitment program will enable AOTA to supply the growing demand for therapists. This means that it is the continuing responsibility of each member to act as a *recruiter.*

Marjorie Fish, O.T.R.
Executive Director.

From the 1957 National Health Forum

This forum, held in Cincinnati from March 20 to 22, might well be described as similar to the activity of a large May pole dance with 450 participants representing 59 member organizations working together in the National Health Council. Each year this group examines a different health problem of broad national interest and the emphasis of the study is on the concerted action that may be needed. The tune played this year was "Better Mental Health, Challenge to All Health Services." The musicians were experts. Their

specialties included branches of science, social science, health, religion and government. The dancers who held the streamers of thought were lay people as well as professionals. They were a heterogeneous group who needed to communicate in a prescribed order to produce a meaningful pattern. This they did and, during the course of the dance, the slogan "Mental Health is Everybody's Business" became the theme of action.

Until this year the forum was always held in New York City. The 1957 meetings were, however, the first step in a plan to take these meetings directly to the American people by scheduling them in different regions. The 1958 forum will be held in Philadelphia.

As occupational therapists many of us have felt pride in our organizational membership in the National Health Council. A tangible focus of this pride has been the excellent health careers guidebook as well as related guidance materials that resulted from a previous forum. The opportunity to actually be a part of the '57 forum, however, increased this good feeling of belonging to the National Health Council family. The subject, the enthusiasm, the communication, and the participation all contributed to the feeling of achievement through belonging and growth. Probably even the sight of the new AOTA banner, prominently displayed behind the speakers' table, contributed to this tone.

An additional new feature this year was an observer corps. Twenty-seven persons from some eighteen different organizations formed ten teams. Each team covered one session a day and, after it, asked several persons in the corridor what they had gained from the talks and discussion. In a wind-up session, the observers turned in comments on the functioning, content, and action implications of the general sessions and group discussions.

Some of the outstanding contributions in terms of ideas presented were made by Reverend George C. Anderson, director of the National Academy of Religion and Mental Health; Dr. Francis J. Braceland, president of the American Psychiatric Association; Dr. Harold D. Lasswell, professor of law and political science at Yale University; Dr. Paul V. Lemkau, director of the New York City Mental Health Board; Margaret Mead, the famed anthropologist; Basil O'Connor, the new National Health Council president; Dr. Fillmore H. Sanford, associate director of the Joint Commission of Mental Illness and Health; and Governor G. Mennen Williams of Michigan. Some of these ideas indicate the forum's potential for spurring and inspiring action on many fronts. Expressions that held meaning for this representative included:

1. "Mental health is a gloriously ambiguous term because it expresses a hope, not a state."—Margaret Mead.

2. Reverend Anderson made many comments on "the whole person" pointing up that the words wholeness and holiness are from the same root. In emphasizing this point he used a number of very descriptive phases as "we're living in a cut flower society." He agreed with Margaret Mead that mental health is a "moving target."

3. Dr. Sanford said that "It may be useful to conceive of mental health as a social movement, as vast and as significant, perhaps, as the Renaissance or the Industrial Revolution."

4. Dr. Lasswell pointed to social climbing and changing roles of men and women on the job and in the home.

"We may not be crazier than ever, but it is crazier than ever to tolerate craziness," he declared. "Mental disease co-existing with science and technology means 'accident prone drivers in chariots of destruction,' home accidents traceable to 'nervous' housewives, and a dent in national security because of mental illness' drain on skills."

5. Dr. Paul Lemkau stressed the importance of bringing home to community leaders the fact that mental illness is not a single disease with a single cause, a single cure, and a single means of prevention. Thus it is a bigger and tougher problem than many of the physical diseases.

6. Dr. David B. Allman, president-elect of the American Medical Association, stressed the need for better psychiatric insight on the part of all health workers.

The action directions from this forum will be most important for us to peruse carefully. They are scheduled to be published in September and copies will be available through the National Health Council, 1790 Broadway, New York 19, New York. Again, some of the action directions and implications that held particular meaning to your representative included:

1. Research.

2. Improving convalescence and rehabilitation services. One strong constructive negative angle on this was the suggestion to break down the fragmentation, compartmenting, and isolation of existing services.

3. The need for inservice training in human relations and good mental health procedures if health workers are to serve as effective counselors to others.

4. Greater emphasis on positive points of happy living.

5. The need for more effective communication and the potency of such communication as contrasted to the impotency of mere knowledge and fancy words.

6. The need for those in mental health to spread their skills and expertness and the comment that this will vary from curing to teaching and from mere survival to the pursuance of lives with creativity.

7. The need to define good personality and the good life.

8. The need to socially accept behavior amputation and pathology in our communities, realizing that it is only when the community itself is emotionally well that it can provide a proper haven for the returned patient.

9. The importance of stressing the challenge and adventure before us.

—Barbara Locher, O.T.R.

From the Educational Secretary

Starting with the next AOTA registration examination, two changes will be in effect. One change affects the date for administering the examination, the second affects the coverage of content in the examination.

Date. From now on, the AOTA registration examination will be administered the last Friday of January and June. The next examination will, therefore, be given on January 31, 1958. Applicants must still be within one month of completing all affiliation assignments.

Content. The former committee on education (now called the council on education) discussed the possibility of reducing the number of, or removing the questions on technical processes of activities and skills from the AOTA registration examination. This would place the emphasis of the examination on the knowledge and understanding of occupational therapy as a treatment entity.

Permission was granted the registration committee in 1954 by the AOTA Board of Management to write a proposal for the procurement of financial assistance for removing technical questions on media from the registration examination and setting up an evaluation of this phase of the students' preparation in another manner. The writing of this proposal was delayed due to other commitments and was referred, in 1956, to the AOTA development committee for scheduling with other proposed AOTA projects.

At the 1957 midyear meeting of the Board of Management, approval was voted for the recommendation of the registration committee that all items covering technical processes of activities and skills be removed from the registration examination as soon as possible, preferably January, 1958. It was further approved that the registration examination be maintained at 300 items covering basic medical knowledge and application of theory of occupational therapy. The items removed should be replaced with application items. The allocation and weighting of areas covered in the examination might need to be adjusted to accommodate this change in the examination.

No consideration was given in this recommendation to the examining of skills techniques in any other manner. It was suggested that more responsibility for evaluating the students' preparedness in media would be placed on the student affiliation supervisor.

Being removed, therefore, from the examination are all questions which specifically test the examinees' "know-how" of the processes and techniques of occupational therapy media. Additional questions requiring the use of such knowledge in the application of these activities and skills to the treatment of patients will replace those removed. To illustrate, examples are given of the types of questions to be deleted and those which will continue to be included in the examination.

To be deleted (processes and techniques of activities and skills)

1. Which one of the following drill points is used in a hand drill chuck?

   A. #9 square shank bit
   B. 1/16" round shank bit
   C. ½" square shank bit
   D. #11 round shank auger bit

2. To sley a warp at 45 ends per inch, which one of the following reeds should you choose?

   A. 8 dents
   B. 10 dents
   C. 12 dents
   D. 15 dents

To continue to be included (application in occupational therapy)

2. Which one of the following OT media would be CONTRA-indicated for an adolescent with rheumatic fever?

   A. paper stenciling
   B. cord knotting
   C. soap carving
   D. clay modeling

3. Which one of the following crafts would be MOST suitable for an epileptic patient in a psychiatric hospital?

   A. braid weaving
   B. carving
   C. metal etching
   D. printing

Any change in the examination must always concern itself with the area allocation within the exam and its relationship to current instruction. The past few years, we have seen many changes in occupational therapy practice and education. In order to assure that the subject matter in the examination will continue to cover the academic and clinical curriculum in occupational therapy, a questionnaire survey of current curriculums is being conducted with the cooperation of the approved schools of occupational therapy and the major affiliation centers. This survey would give us a basis for a reallocation and reweighting of the areas covered in the examination.

Mary Frances Heermans, O.T.R.
Educational Secretary.

Sorry

Due to error in compilation, we are again listing the names of those who passed the June, 1957, registration examination with honors: Mary A. Curtis, Mary Kaserman, Gloria R. Lucker, Gayle L. McKerrow, Jane van Dyke.

FEATURED O.T. DEPARTMENTS

OCCUPATIONAL THERAPY IN NEW ZEALAND

Joyce K. Rosser

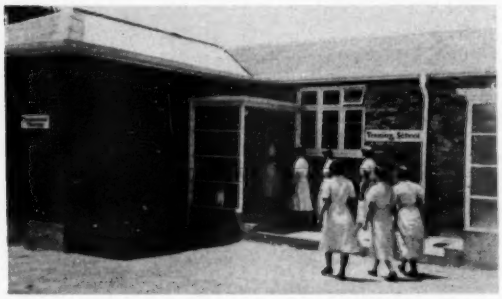
New Zealand School of Occupational Therapy in Auckland

New Zealand is a small oasis of land in the South Pacific Ocean, some 1,200 miles from our nearest nation neighbor of Australia. The country is long and narrow, consisting of two large main islands (North, 44,280 square miles and South, 58,090 square miles) and one small (Stewart, 670 square miles) and a number of islets. It lies approximately north and south for a length of 1,000 miles and is in no part wider than 150 miles. There is a "backbone" to each island of a partly volcanic mountain chain, and the country offers a temperate climate with beautiful scenery of every variety.

The first official immigrants to New Zealand, only a little over a century ago, were of British birth, and New Zealand is a member of the British Commonwealth of Nations. We have opened our doors to recent immigrants from many other countries and the New Zealander is becoming a person in his own right, not a little English cousin. However, it was because of this tradition that we looked to England for help with the establishment of occupational therapy.

This country has always been to the fore in the development of social welfare, age pensions having been paid for over fifty years. In 1935 the first labour government introduced a system of social security whereby all incomes are taxed to provide a wide range of free hospital services, medical benefits and pensions. These have been continued and improved by succeeding administrations, and obviously all health services must be under government control. This has caused the development of a system for occupational therapy students in which they are employees of the health department and are paid a salary during training.

After the early establishment of hospitals, women's auxiliary groups were formed and contributed greatly to the well-being of patients by providing entertainments and handwork. Some very valuable work was done, but at best this was a spasmodic and unscientific "extra." The earliest date of an official establishment including anything approximating occupational therapy of which we have a record is in 1915 in a convalescent hospital for returned servicemen.



Students entering the New Zealand School of Occupational Therapy

The first qualified occupational therapist arrived in Auckland in January, 1940, having been appointed by the Mental Hospitals Department (now merged under the Ministry of Health). She was Miss Margaret Inman, a trained nurse and a graduate of Dr. Elizabeth Casson's Dorset House Occupational Therapy School, Bristol, England.

The outbreak of World War II in September, 1939, focussed the attention of the authorities on the preparation of the hospital services for the treatment of war patients. Officers of the health department visited the Auckland Mental Hospital to see the work being carried out, with the object of ascertaining the possibility of the establishment of a training centre there. As a result of this visit it was decided to establish in the first place, as a war measure, a short course for the training of occupational therapists. People with previous training bearing on the subject were accepted and the school was opened late in 1940 with six students. It was fortunate in obtaining some particularly fine women who made an excellent beginning for this new profession.

In 1946 the first school building was opened on the grounds of the Auckland Mental Hospital and the principal was able to separate her new students from the congestion of the small department in the hospital itself. Courses were then commenced each six months with classes of students gradually increasing in number up to ap-

General hospitals	Medical and surgical	22
Psychiatric hospitals	All types of mental disorder including epilepsy and feeble-mindedness	12
Geriatric hospitals		3
Tuberculosis sanatoria	Long term patients	2
Cerebral palsy institutions	One residential unit and the others day schools	5
Children's institutions	Orthopaedic conditions mainly	2
Institutions for the blind		4
Residential unit	Physically handicapped adults	1
Rheumatology unit		1

Hospitals in New Zealand with Occupational Therapy Departments

proximately sixteen at present. The principal is Miss Hazel Barton, who was one of the first graduates from the 1940 class and who also studied at Toronto University, and her assistant is Miss Frances Rutherford, a New Zealander who studied at the Liverpool School of Occupational Therapy.

During the years 1947 to 1949 the draft regulations for legislation were prepared, to establish occupational therapy on a constitutional basis and the law, passed in 1950, finally took effect in 1955. Under this law, all qualified occupational therapists must have state registration, and the Board consisting mainly of representatives from the Ministry of Health and occupational therapists deals with all matters of training.

In 1948 an association of the therapists themselves was formed to help members working in widely scattered parts of the country feel that they are part of the whole. Considering its recent beginning, and the slow increase of membership the Association has made very good progress—its members numbering almost 200. It is recognized by the Government, which has granted it representation on the Occupational Therapy Board, and it publishes a quarterly journal, besides arranging for conferences, refresher courses, etc.

The work in individual institutions is very similar to that in other countries, with the same variety of amenities, co-operation and recognition and the same difficulties of lack of staff and space. In the following institutions the programs vary according to the number of beds and the type of patient. The figures can only be approximate as the situation is always changing, but they will give some idea of the growth of the work over the past seventeen years.

In conclusion we would point out the main features of occupational therapy in New Zealand in which it may differ from that of other countries:

One training school for the whole of the country controlled by a state appointed board.

Payment of students during the training period.

Preliminary six months' theoretical work in the school, and two years practical work in approved hospital departments of different types.

The dual physical and psychiatric training which we feel is invaluable in that all occupational therapists must necessarily be good psychologists, and that the mind and body of a patient cannot be separated by an arbitrary dividing line.

Of course these differences are mainly ones of local administration and have developed to suit New Zealand conditions. We all work as part of the great team of specialists, striving for the recovery from disease or injury of our fellow citizens.

The Changing Role . . .

(Continued from page 282)

hospital and also aid him in working effectively and cooperatively with others in these simple but available tasks.

This use of occupational therapy in reducing the expectancy set seems indeed quite obvious when it is described, but like most obvious things it hides a complex etiology. It is a phenomenon which we have taken for granted for many years and it is only recently that we have begun to study it scientifically. There is every expectation that the years to come will show the fruition of our efforts to bring the scientific method to bear upon this important and neglected area of recreation. We are beginning to realize that these simple activities are in reality extremely complex human interactions with many subtle features, and that they can teach us an immense amount, not only about how patients get well in hospitals or why they fail to improve, but how we ourselves can find happier, more relaxed, contented, more useful and efficient lives.

W. F. O. THERAPISTS

Report of the first meeting of the Council of the World Federation of Occupational Therapists held in the United States.

Meetings of the Council of the World Federation of Occupational Therapists were held at Huston Hall, Philadelphia, by kind permission of the University of Pennsylvania from October 15 to 19, 1956. Representatives of member organizations in Australia, Canada, Denmark, Great Britain, India, Israel, Sweden and the United States of America attended. Apologies for absence were received from the New Zealand and South African Associations.

The President, Miss M. B. Fulton, was chairman.

The most important subject of discussion was the implementation of the aims of the World Federation, mainly:

1. To act as the official international organization for the promotion of occupational therapy; to hold international congresses.
2. To promote international co-operation among occupational therapy associations, occupational therapists, and between them and other allied professional groups.
3. To maintain the ethics of the profession and to advance the practice and standards of occupational therapy.
4. To promote internationally recognized standards for the education of occupational therapists.
5. To facilitate the international exchange and placement of therapists and students.
6. To facilitate the exchange of information and publications and to promote research.

It was noted that while some progress had been made in respect to 1 and 2, by such means as holding of the Edinburgh Congress, participating in the sixth international congress of the International Society for the Welfare of Cripples, having permanent representation on the Committee of World Organizations Interested in the Handicapped, and sending delegates to the congress of the World Confederation for Physical Therapy, that much still remained to be done and that recognition by the World Health Organization as a non-governmental organization, which has not yet been granted to WFOT must depend to a considerable extent on implementation of the articles.

During the Council meetings advice was received that publication of documentary statements on basic professional procedures and policies (which should be available in French and Spanish as well as in English) would be of great value in the international development of occupational therapy and would also provide evidence of work for the profession and therefore for the patient (rather than for the personal advancement of individual members of the profession). It was also pointed out to the Council that in obtaining World Health Organization recognition pressure from national government representatives is an important factor.

Another factor which emerged from the discussions with the United Nations' representative was the urgent need for more and better professional publicity.

During the course of the Philadelphia meetings, Miss Clare S. Spackman of the USA was appointed president-elect to take office when Miss M. B. Fulton, M.B.E., completes her term as president on March 31, 1957.

Miss Dulcie Goode of Australia was elected second vice-president. Mrs. Thelma Cardwell of Canada was elected assistant honorary secretary-treasurer.

The International Society for the Welfare of Cripples has invited the World Federation of Occupational Therapists to participate in its seventh international congress to be held in London and a meeting has been arranged to take place at St. Thomas's Hospital on Tuesday, July 23, from 12 to 3 p.m. The second international congress of the WFOT will be held in Copenhagen from August 11 to 16, 1958, and it is hoped that this will be preceded by a study tour in Great Britain. The Council will meet in Australia in 1960 and in 1962 the third international congress will be held in Philadelphia, USA. It is thought probable that the following Council meeting will be in Africa or Asia.

This rotation of meetings on the territory of member organizations affords an excellent means of stimulating public interest in the profession and is the only equitable arrangement in an international body.

In order to make progress, funds are needed. It was resolved to appeal to all member organizations for additional financial support.

In addition to the formal meetings of the Council, a very full program of entertainment was arranged for delegates and delightful hospitality had been arranged for all. Many delegates also had the privilege of attending the annual conference of the American Occupational Therapy Association at Minneapolis which was a most stimulating experience. Those who also had the additional pleasure of participating in the convention of the Canadian Association were doubly blessed since their visit closed as it had begun, with the valuable experience of an enthusiastic and well planned professional meeting.

(Mrs.) Constance Owens
Honorary Secretary.

MIDYEAR MEETING OF THE BOARD OF MANAGEMENT

American Occupational Therapy Association

CORONADO HOTEL, ST. LOUIS, MISSOURI
April 6-7, 1957

Roll Call

Members Present
Miss Mary Britton, O.T.R.
Miss Marion C. Crampton, O.T.R.
Miss Marie Louise Franciscus, O.T.R.
Miss Margaret Gleave, O.T.R.
Lt. Col. Myra L. McDaniel, O.T.R.
Mrs. Arvilla D. Merrill, O.T.R.
Miss Elizabeth Messick, O.T.R.
Mr. Laurel V. Nelson, O.T.R.
Miss Margery Peple, O.T.R.
Miss Mary Reilly, O.T.R.
Sister Jeanne Marie Bonnett, O.T.R.
Miss June Sokolov, O.T.R.
Miss Florence M. Stattel, O.T.R.
Miss Caroline G. Thompson, O.T.R.
Miss Beatrice D. Wade, O.T.R.
Miss Wilma L. West, O.T.R.
Miss Elizabeth Whitaker, O.T.R.
Miss Marjorie Fish, O.T.R.)
Miss Mary Frances Heermans, O.T.R.) Ex Officio

Members Not Present
Dr. William R. Dunton, Jr.
Miss Ethel Huebner, O.T.R.
Mrs. Margaret K. Mathiott, O.T.R.
(Proxy: Mrs. Merrill, O.T.R.)
Mrs. Ivabelle B. Rhodes, O.T.R.
Sister Jeanne Marie Bonnett, O.T.R.
(Saturday only)
(Proxy: Miss Messick, O.T.R.)

Presiding: Lt. Col. Ruth A. Robinson, President

Minutes of the previous meeting of the Board of Management, held in Minneapolis, October 1956, were presented for approval, and one correction was noted.

It was voted that the minutes be approved as corrected.

Executive Reports

Treasurer: Miss Wilma West, O.T.R.

The treasurer noted that where there were drastic increases in the proposed 1957-1958 budget, there were well-considered bases in each instance and also that effort had been made to anticipate contingencies. In the education fund, a probable deficit of $3300 was foreseen for the coming year, representing three-fifths of the unbudgeted salary of the new education assistant; the remaining two-fifths of the salary for this new position has been absorbed either in terms of anticipated increases in revenue or further cuts in expenses.

Three budget items on which action had been taken at the February 8 meeting of the executive committee were reported to the Board of Management: (1) it was voted to increase our membership fee in the National Health Council (at the request of the Council) by fifteen per cent, thus bringing our total annual contribution to $115; (2) $200 was voted as a contribution to the Second Congress of the World Federation of Occupational Therapists, $50 in the fiscal year 1957, and $150 in the fiscal year 1958; (3) it was voted to continue to have the executive director's secretary attend semi-annual meetings if it proves feasible financially.

The following figures indicate potential revenue increases in the general fund: from non-member practicing therapists—$3100; from sustaining members—$220; re-registration arrears for the five-year period before losing registration—potential $3000; $6300 total potential revenue increase.

Group discussion elicited the suggestions that a "package deal" be considered, or lower registration fee with membership than without membership; that interpretation of membership services be offered through state associations as a prelude to the raising of dues; that steps be taken to encourage sustaining memberships. It was recommended that the Board of Management consider suggesting an increase of dues to $15 to the House of Delegates for discussion at their annual meeting in 1957; that consideration of a "package deal" be referred to the committee on revenues; and that some definite action should be taken regarding sustaining memberships to effect an increase in that source of income.

It was voted that the Board of Management recommend that the membership consider an increase in dues to not less than $15, to be effective in the fiscal year 1959.

It was voted that the committee on revenues give further study to the problem of permitting graduating therapists to take out partial memberships in June to tide them over until November.

It was agreed that the problem of registration fees be explored by the committee on revenues so it can be related to the package deal and to the Yearbook problem.

It was voted to accept the report of the treasurer with appreciation.

Committee on Revenues: Miss Clare Spackman, O.T.R., Chairman.

The chairman referred to the three recommendations in her report, and emphasized the importance of Item 2.a., the matter of bequests. She suggested that a committee be formed with representation from every state association, to promote this idea. Group discussion favored change of committee title to "Committee on Development of Revenue" and also the creation of a 40th Anniversary Fund.

It was voted that consideration be given by the committee to a change of name, and to the 40th Anniversary Fund.

It was voted that the report be accepted with thanks.

Executive Director: Miss Marjorie Fish, O.T.R.

The executive director presented a statistical statement on number of members and registrants. This indicated 317 registrants practicing but non-members. Follow up letters had been sent to these individuals, to their schools and state presidents.

Twenty out of forty advertisers for the Yearbook were package deals, and a total of $1860 was received in revenue.

Information on grants was supplied as follows:

OVR regional institutes: $1200 remains in the budget for publication of the proceedings.

OVR institute-conference grant: Miss Cecile Hillyer, Chief of Division of Training, Office of Vocational Rehabilitation, has advised that we would receive word by August 31 re our application for a continuing grant. This application is to be submitted in May and should incorporate the remaining amount needed to see us through the 1957 institute, as well as the budget for the new grant. OVR is planning allocations for occupational therapy on a five-year plan, to be requested annually.

NFIP continuing grant for 1957-58 recruitment: It has been indicated the trustees will approve this grant.

United Cerebral Palsy: $10,000 has been granted for undergraduate scholarships for 1957-58.

NIMH extended study: As detailed in the minutes of the executive committee meeting of February 8, two recommendations were offered: 1. That a request for a continuing study grant go forward, and that the proposal for this be written up by a committee selected by the AOTA executive committee. That consideration

be given to calling a meeting of representatives of allied organizations to discuss some of the factors that made up the Allenberry conference. Action has been recommended and it will be brought to the attention of the Board at a later date.

See "Other Business" in these minutes for further action on grants.

The salary study conducted with the seventh company salary questionnaire was circulated to the membership, and only a 25% return was received. The Board discussed the possibility of sending out another, more explicit questionnaire in view of the importance of this data.

The American Hospital Association 1957 institute in Seattle had to be canceled because of insufficient enrollment. It is hoped a future institute can be planned for this area.

It was voted that the executive director be authorized to follow up on the salary study in ways which she will determine best in implementing suggestions made by the Board.

It was voted to accept the report of the executive director with appreciation.

Speaker of the House of Delegates: Mrs. Arvilla Merrill, O.T.R. (for Mrs. Mathiott).

It was reported that Miss Mary Van Gorden is the new secretary of the House, following the resignation of Miss Dorothy Deer. The Association had received a $50 gift from the Kansas OT Association and part of this was designated to defray the cost of shipping the secretarial files from Oklahoma to Minnesota.

Various House committees have submitted reports on expense funds, OT treatment fees, and a study of lowered membership fees for non-practicing O.T.R.'s.

The recommendation was repeated that the next speaker's letter to the delegates contain further explanatory information on the new 1957 conference plan.

It was voted to accept the report of the speaker with appreciation.

Editor of AJOT: Mrs. Lucie Spence Murphy, O.T.R.

A suggestion was reported that the 1956 conference issue of AJOT carry the speeches only, and the institute proceedings be published together with the 1956 OVR regional institute proceedings. A remaining balance of OVR funds could, with permission from OVR, be utilized for this purpose.

It was voted that the August issue of AJOT include the papers from the 1956 conference, and that the executive director further investigate the feasibility of including the AOTA institute proceedings with the OVR regional institute proceedings in a combined publication.

There was discussion on the possibility of publishing an annual to include proceedings, committee reports, and technical articles including those submitted in AJOT.

The matter of charging for repeated insertions of the same notices was discussed.

It was voted to publish the initial announcement of educational opportunities gratis, and to charge for subsequent announcements at the full advertising rate.

It was voted to accept the report of the editor with great appreciation.

Director of Public Information: Miss Rheta Glueck.

The new AOTA brochure "Play on the Recovery Team" is based on and reprinted with permission from the *Health Career Guidebook*, published by the National Health Council and supported in the public interest by the Equitable Life Assurance Society of the United States. Hospital administrators, country-wide, have received a series of kits including our black and white brochure and programming and publicity suggestions for spot writing. Salk vaccine posters will be circularized through this Association at the request of NFIP.

The Hall of Health exhibit at the Smithsonian Institute had to be postponed because budgetary restrictions did not allow for the three-dimensional exhibit required.

It was voted to accept the report of the director of public information with thanks, and the executive director added her personal appreciation for the high caliber of work and the achievements of Miss Glueck.

Educational Secretary: Miss Mary Frances Heermans, O.T.R.

The survey of enrollment in the schools has not been completed at the present time and no statement on current trends can be given until all the data is available. This survey was instituted not only for routine information, but also for its relationship to the recruitment program of the last three years.

Much interest has been expressed in foreign schools of occupational therapy.

Slides and stories from the 1956 AOTA institute are available for loan at the national office which cannot, however, undertake to screen the materials in response to individual requests.

An offer of material was received from Sister Jeanne Marie with thanks. Although the AOTA education staff could not screen the material, and a financial problem arose from the mailing costs, it was suggested that recipients might be willing to pay postage. Revenue from a possible service fee to cover somewhat more than the cost of mailing alone, was discussed.

It was voted to accept the report of the educational secretary with thanks, and the executive director added her personal appreciation for the high standard of work performed.

Reports of Chairmen of Standing Committees

Permanent Conference Committee: Mrs. Winifred C. Kahmann, O.T.R.

The 1957 conference will be held at the Hotel Carter, Cleveland, October 18 to 25. Pre-conference meetings will begin Thursday night instead of Friday, as previously scheduled. An OVR grant has been received for this institute-conference, and a meeting of the activating committee for the conference was held in New York on February 9-10, following which Mrs. Margaret Mathiott, on leave from Ohio State University, was appointed as coordinator for development of the program, to work from the national office.

It was voted that the form of procedure for the 1957 annual business meeting be changed to include only reports from the executive director, treasurer, speaker of the House of Delegates, and nominating committee chairman, and that these reports be followed by the Eleanor Clark Slagle Lecture. It was suggested that there be time allocated in the final Friday session for committee chairmen to present very brief reports interpreting the work of their committees in terms of the role of OT (Conference theme as discussed throughout the week, and future trends) and also to answer questions from the membership (this to replace the conventional reports of committee chairmen as given during the business meeting in previous years).

It was voted that the activating committee be highly commended for the masterful job they have done for the 1957 conference.

The 1958 conference is scheduled for New York City. Miss Frieda Behlen has accepted the chairmanship of the local committee. Hotel facilities are being investigated with particular reference to the New Yorker, Waldorf-Astoria, and Statler.

It was voted that the selection of a hotel for 1958 be referred to the discretion of the conference chairman and the committee in New York, giving them an oppor-

tunity to consider all factors.

It was agreed that the 1959 conference will not be held in Denver; that of the three possibilities suggested the one most able and ready to accept this responsibility be selected; and that this be left to the discretion of the permanent conference chairman.

Special Studies Committee: Miss Florence Stattel, O.T.R., (for Miss Zimmerman).

Each liaison chairman has received copies of the minutes of the annual meeting, operating procedures of the special studies committee, lists of consulting members and a summary of objectives. Fifteen consulting members have agreed to serve on the committee. OT bibliographical material will be compiled and submitted to the chairman in each state association in regard to studies that are available, and sources where they can be obtained. Pictures were submitted to the committee on clinical procedures, reviewed by them, and turned over to the editor of AJOT. A survey form for studies being done by therapists is in preparation, and it was proposed that this be sent out with the Newsletter, returns sent to state chairmen for compilation on the state level, then to the national special studies committee for final compilation on the national level. It was suggested by the chairman that a proposed outline for ascertaining information be prepared, and that it be referred to the graduate study committee to prevent conflict or duplication with their work.

It was voted that the report be accepted with appreciation.

Legislative and Civil Service Committee.

It was reported that the chairman, Miss Virginia Caskey, has been ill and expressed her regret that she was unable to prepare an interim report for this meeting.

Council on Education: Miss Caroline Thompson, O.T.R.

The chairman reported the deliberations of the council re the appointment of a consultant; Professor Earl W. Anderson of the department of education of Ohio State University has been suggested. It was recommended that the utilization of liberal arts elements, in conjunction with the professional, be one of the special topics on which Dr. Anderson's guidance be sought.

The council voted that the registration committee and the education office be empowered to remove the skills items from the registration examination without replacement by other items. Another suggestion in this area, arising from Board discussion, was that the skills and activities questions be removed from the registration examination and that they be replaced as soon as feasible by clinical application questions using skills and activities.

The following report topics were mentioned briefly: AMA advisory committee on OT education (three-man team will be used for school inspection surveys—two physicians and one therapist); recommendations emanating from the OVR regional institutes; forms and letters; master's degree for OT's; planned program for establishment of new schools.

The Board requested that the chairman write out from her excellent notes the philosophical statement on OT which she gave relative to the need of defining occupational therapy more specifically with reference to function than with reference to media.

It was voted to accept the report of the chairman of the council on education with thanks.

Registration Committee: Miss Mary Frances Heermans, O.T.R.

Two items were referred to the Board for consideration:

1. International reciprocity statement: The registration committee had prepared a second revision and asked approval for broadening of concept. Exception was taken to c.2 under 5, including the word "elsewhere," and change of word "training" to "evaluation."

It was voted that the revisions be accepted with the changes indicated, and that the word "training" be changed to the word "evaluation" in two places.

It was voted that the recommendations made by the registration committee be accepted as noted on Exhibit B: "The registration committee recommends to the Board of Management, through the council on education, that all items covering technical processes of activities and skills be removed from the registration examination as soon as possible, preferably January 1958. It was further recommended that the registration examination be maintained at 300 items covering basic medical knowledge and application items. The allocation and weighting of areas covered in the examination might need to be adjusted to accommodate this change in the examination. (No consideration was given in this recommendation to the examining of skills techniques in any other manner. It was suggested that more responsibility for evaluating the students' preparedness in media would be placed on the student affiliation supervisor)."

Committee on Clinical Procedures: Lt. Col. Myra McDaniel.

It was reported that the third printing of *Objectives and Functions of Occupational Therapy* will be placed in the hands of another printer for better format and organization. The committee recommended that no third installment be published at this time, but that this material be incorporated in the next printing with previous material.

The work status of the following subcommittees was reviewed (progress from November, 1956, to April, 1957): administration, general medicine and surgery, tuberculosis, pediatrics, physical disabilities, and psychiatry.

It was voted that there be no publication of a third installment, per se; in lieu of which material normally constituting the third installment would be incorporated with the original and supplement and printed as a complete single edition in the fall of 1957.

Committee on Recognitions: Miss Florence Stattel, O.T.R.

It was reported that this committee has just started to function as a committee, and a request was made for scheduling it as a meeting group prior to the next executive committee meeting. In this way the committee could submit its recommendations to the president and eliminate the necessity of further executive committee action. Screening of candidates for the Eleanor Clark Slagel lectureship will continue, and material will be turned over to a committee comprised of the past president, speaker of the House of Delegates, and the chairman of the committee.

It was voted to accept the report of the chairman of the committee on recognitions with appreciation.

Committee on Recruitment and Publicity: Mrs. Frances Shuff, chairman.

This report was sent to Board members in advance. In the absence of the chairman and since no action was required no discussion ensued.

It was voted that the report be accepted with thanks.

Reports of Chairmen of Special Committees

Project Committee on Recognition of OT Assistants: Miss Marion Crampton, O.T.R., chairman; Miss Elizabeth Messick, O.T.R., discussant.

The chairman reported that this group, with status changed at the last annual meeting from special committee, to project committee had been charged with im-

plementing six recommendations, and reviewing the civil service implications. This has been done in relation to the recommendations submitted by fourteen state associations. Approval was requested on "Minimum Requirements of an Acceptable Training Program for Occupational Therapy Assistants" as distributed to the Board prior to the meeting. Two suggested insignia were presented for Board choice. Discussant offered the suggestion that another committee be appointed to study this curriculum material.

Group discussion concerned itself with appropriate personnel for a reviewing committee, specific curriculum content and terminology, consultation with other groups, such as the clinical procedures committee where areas of interest would overlap, and possible constitutional changes which might be involved. The Board also discussed the travel expenditures of this project committee.

It was voted that this report be accepted in principle, with the recommendation that it be submitted for review through such channels as a committee of the House of Delegates, the medical advisory council, and appropriate standing committees. It was further recommended that consideration be given to reactivating the AOTA constitution revision committee to study ramifications.

It was recommended that the committee go on with the curriculum study under the chairmanship of Miss Crampton, and that appropriate persons be designated to review it.

It was voted that the larger size insignia be adopted, and that the wording read "Certified" to be followed by the descriptive word of the particular specialty involved.

It was voted that an expression of gratitude be extended to the committee for an excellent piece of work, and that a special vote of thanks be extended to the chairman.

Committee on OT Reference Manual for Physicians: Miss Marguerite Abbott, O.T.R.

The report was presented by Miss Marie Louise Franciscus in the absence of the chairman, Miss Marguerite Abbott. Discussion as to further material to be included in the manual produced suggestions for coverage of multiple sclerosis, arthritis and brain tumors.

It was voted the report be accepted with thanks.

Committee on National Office Personnel Policies: Miss Ethel Huebner, O.T.R.

The report was presented and reviewed by Miss Wilma West, in the absence of the chairman, Miss Ethel Huebner. As committee study will not be completed until the 1957 annual conference, the report requested Board action on only one point, national office staff work hours. The treasurer also reviewed the preliminary data relative to a possible health and retirement plan, to be entered into by the Association.

Formulation of S.O.P. for New Members of the Board of Management: Miss Beatrice Wade, O.T.R.

The report was presented by the chairman for Board discussion on personal sponsorship of new members by previously appointed members, and the development of "information kits."

It was voted that the committee report be accepted with the addition of an eighth item to be included in the information kit for Board members, as follows: "(8) a brief statement on the Board including: characteristics of its composition (i.e., geographic and specialty representation sought); format and length of twice yearly meetings scheduled to precede and/or follow mid-year and annual meetings; policy-determining (as contrasted with working) functions; functions of the executive committee during interim periods, with particular reference to acting in emergencies, and as the personnel and finance committee, all subject to subsequent Board approval; and the manner of Board action on committee, executive and officer reports."

Other Business

Grants:

National Foundation for Infantile Paralysis

The curriculum study proposal has not been accepted by the Foundation in its present form. They indicated a serious interest in supporting the study and requested that it be resubmitted after being revised on a less ambitious scale.

It was voted to accept the recommendation of the council on education that a project writing committee with representation from the council be used for this purpose, this committee to be appointed by the president in consultation with the executive director.

Office of Vocational Rehabilitation, Continuing Grant

It was voted to formulate a request for support of a field consultant in rehabilitation on a five-year basis. It was suggested that the fields of physical disabilities and psychiatry be specified, which would necessitate alternating personnel during the five-year period.

National Institute of Mental Health, Meeting of Allied Groups.

One of the recommendations emanating from the NIMH psychiatric conference, November, 1956, at Allenberry Inn, Boiling Springs, Pennsylvania, was that this Association bring together representatives from allied groups for discussion in the interest of improved patient care. It was proposed that a two-day meeting be held for representatives of organizations whose members function in activity programs for psychiatric patients, this meeting to be held at the AOTA national office, with expenses to be paid by the participants' respective organizations. A report was rendered to the Board on the endorsement of this project by the council on medical education and hospitals of the American Medical Association.

It was voted that the letter of invitation be sent and that the meeting be arranged at the national office in New York.

National Research Laboratory

The president indicated that the chairman of this committee had made inquiry relative to its status. It was agreed to inform her of the sequence allocation of this grant within the grants schedule of the basic development plan; its present status indicates possible assignment in 1960.

Washburn University Project

An invitation was extended to the Association by Dr. William H. Key, Director of the Adjunctive Therapy Research Project of Washburn University in Topeka, Kansas, to send a representative of this Association to a meeting to be held on the campus of Washburn University, April 25-27. The university had received a grant from the Office of Vocational Rehabilitation for a research project in the psychiatric adjunctive therapies to determine the need for personnel trained to coordinate the activities of all the special therapists working with patients in a psychiatric hospital, and to assess the usefulness of a training program in adjunctive therapy.

The president advised that the executive director would represent the Association at this meeting.

1958 *Midyear Meeting*

It was recommended that the meeting be held in Denver, Colorado, the early part of April.

There being no further business, the meeting was adjourned.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director

DELEGATES DIVISION

COLORADO

Delegate-Reporter, Patricia Bodine, O.T.R.

Denver was fortunate to be chosen as the site for one of the OVR-AOTA institutes during the past year. Many of our therapists spent their free time working on the organization of the institute, but all of those who attended felt the time spent had been well worth their effort.

Because of the distance involved, and geographical location of many Colorado therapists, attempts are being made to form a district in the southern part of the state. By doing this, we feel that we can stimulate more active participation by all our members.

One of our most enjoyable events this year, was our annual joint meeting with the physical therapists and speech therapists at Fitzsimons Army Hospital. This year the occupational therapists were responsible for the program for the evening.

Two of our members, Theresa Anema and Patricia Bodine, have been chosen members of the professional advisory board of the Colorado Mental Health Association. Participation on this newly formed board will stimulate new enthusiasm and cooperation of all the ancillary services connected with the mental health program.

Several well-written newspaper articles have featured occupational therapy departments and their roles on the rehabilitation team. These articles have furnished a means for recruitment of new therapists.

Copies of the publication *At Your Fingertips* continue to be available from the Smith-Brooks Publishing Company, 8000 East 40th Avenue, Denver. Proceeds from sales are being used for scholarships for occupational therapy students at Colorado State University in Fort Collins.

OFFICERS

President	Russell Mosier, O.T.R.
Vice-President	Gloria Tolaro, O.T.R.
Secretary	Joyce Ballard, O.T.R.
Treasurer	Mary Ann Trautman, O.T.R.
Delegate	Patricia Bodine, O.T.R.
Alternate Delegate	Lois Arnold, O.T.R.

CONNECTICUT

Delegate-Reporter, Marian E. Wright, O.T.R.

The past year of 1956-57 has been one of transition for Connecticut occupational therapists. Many of the key, well seasoned members have left the state, others have had to curtail their association activities due to domestic obligations. The office of presidency changed three times during the biennial from Mrs. Alice Rogers to Miss Mildred Sleeper to Mrs. Bess Lande. In spite of this, with a number of new graduates and already practicing O.T.R.'s joining our ranks, the membership has shown a slight rise.

Four general meetings were called: in September at Norwich State Hospital which enabled the membership to tour the newly dedicated two million dollar occupational therapy building, Russell Hall; in November at Woodruff Restorative Center in New Haven for the Minneapolis conference report; in March at Grace New Haven Hospital; and in May, at East Hartford High School where COTA met in conjunction with the Connecticut medical society meeting. Dr. John Donnelly, clinical director from the Institute of Living, Hartford, was the speaker at the afternoon session.

Area committee members appointed by the recruitment chairman handled brochures and other publicity materials, and served as clearing centers for speaker requests. The individual occupational therapy departments took responsibility for supplying their immediate localities with speakers and printed matter. Connecticut State Hospital at Middletown participated in a series of 15-minute radio talks over Station WCNX describing unit by unit, the specific media and functions of occupational therapy in psychiatry. A portable exhibit on occupational therapy was set up by the recruitment chairman, Miss Irene O'Brock of Woodruff Center, which is available for membership use.

Nineteen fifty-seven and fifty-eight gives promise of a stabilizing year for the Connecticut Occupational Therapy Association with the following new officers at the helm:

OFFICERS

President	Bess Lande, O.T.R.
Vice-President	Robert Belyea, O.T.R.
Recording Secretary	Anne Herrington, O.T.R.
Corresponding Secretary	Irene O'Brock, O.T.R.
Treasurer	Betty Marie Clerc, O.T.R.
Delegate	Marian E. Wright, O.T.R.
Alternate Delegate	Patricia Plaisted, O.T.R.

IOWA

Delegate-Reporter, Helen Brom, O.T.R.

Real purpose and direction have been realized this year in the Iowa Association. The scholarship fund became a reality in function as well as purpose. Past years of dreams, planning and fund raising culminated in the actual awarding of a scholarship to a qualified person in February, 1957.

Establishing a scholarship fund has been in the thinking of the Iowa Occupational Therapy Association members for a number of years. Originally created from the proceeds of rummage sales, last year it was decided this fund would need to have an authorized framework of rules to govern its disposition, as well as a permanent policy for maintaining it so that one or two scholarships might be available each year.

Last October the Iowa Association approved rules governing the amount and type of scholarship to be awarded, qualifications for scholarship applicants and methods of maintaining the fund. (Those interested in the details may write Mrs. Helen Beck, Psychopathic Hospital, Iowa City, Iowa.) This scholarship is now listed in the State University of Iowa office for student aid and will be available for the fall semester, 1957. Thus the Iowa Association has made a concrete beginning in helping to supply the need of occupational therapists throughout the land by helping a student complete the necessary training.

The Iowa Occupational Therapy Association consists of thirty active members, four associate members, and two state active members; meets bi-annually and publishes a bi-annual newsletter.

OFFICERS

President	Gyla Fairchild, O.T.R.
Vice-President	Jack Dack, O.T.R.
Secretary-Treasurer	Helen Beck, O.T.R.
Delegate	Helen Brom, O.T.R.
Alternate-Delegate	Eleanor Reeves, O.T.R.

MISSOURI

Delegate-Reporter, Marion Stumpf, O.T.R.

"Searching for New Ideas" was the theme for the program committee for 1956-57. The membership continued its program of meeting at various hospital centers throughout the St. Louis area, and a varied program of

business meetings, guest lecturers and craft demonstrations constituted the program for the year.

There were many new plans and policies inaugurated, one of which was the monthly newsletter entitled "Our MOTivAtions" published and compiled by the publicity committee. This has served as a meeting notice as well as presentation of any communications of interest to the general membership, annual committee reports, general announcements and job opportunities. This newsletter is mailed to all members of the Missouri Occupational Therapy Association prior to the regular monthly meeting, and one mailing has been sent to all registered therapists in the state of Missouri.

The study and research committee compiled the "Handbook of Procedures" to serve as an answer to the perennial question of officers and committee chairmen—what are my duties? It was compiled to serve as a guide for officers, committee chairmen and members as stated in the constitution and by-laws of the Missouri Occupational Therapy Association, *Roberts Rules of Order, Revised*, as well as duties established by custom. It is hoped that this handbook will afford members the opportunity to be well informed as to the policies and structure of the Association, and thereby further the realization of the goals of Missouri Occupational Therapy Association.

The newly formed ways and means committee had several money making projects throughout the year. The most outstanding as regards financial return was the theatre party in which 144 tickets were sold. The committee was able to realize a profit on each ticket sold, with little or no expense incurred, for a regular scheduled performance at the American Theatre in St. Louis. The return on the committee projects is used to supplement the treasury, since we are unable to depend totally on membership dues for expenses.

On April 6, 1957, Missouri was host at a tea given at the Rehabilitation Center of Greater St. Louis for the mid-year meeting of the American Occupational Therapy Association which was held in St. Louis. Approximately 100 attended this event.

OFFICERS

President	Ruth Leebrick, O.T.R.
Vice-President	Theresa Burmeister, O.T.R.
Secretary	Carolyn Crossen, O.T.R.
Treasurer	Clothilde Burns, O.T.R.
Delegate	Marion Stumpf, O.T.R.
Alternate Delegate	Joanne Silhavey, O.T.R.

Letters to the Editor

To the Editor:

I am writing in regard to the article entitled "Hemiplegia and Concomitant Psychological Phenomena" by Carl H. Delacato and Glenn Doman. The concept expressed by the authoris concerning "amorality" as a trait that is seen in a majority of hemiplegics seems to the undersigned to be well intentioned but misleading. In my own experience over a period of many years, this concept of amorality as developed by the authors has not been evident in a majority of hemiplegics seen by me. On the contrary, it is the exception rather than the rule and appears to occur in those patients who prior to the onset of their CVA were somewhat immature in their personality development and may have previously manifested some asocial traits earlier in their life experience.

Not only do I disagree with the idea that the majority of hemiplegics show amorality, but I would also venture to disagree with the recommended treatment for behavior that the authors choose to call amorality. The careful worker, or strict individual who has suffered from a CVA seems to do better by resuming activities on a graduated scale rather than being forced into a situation of extreme self-criticism and criticism on the part of therapists.

I would have no quarrel with that portion of the article dealing with the change in the attention span as manifested by patients who have suffered a CVA.

In summary, the point of this letter is that the authors have taken a symptom shown by a minority of patients and ascribed this symptom to a majority of patients who have suffered a CVA.

Ben L. Boynton, M.D.

To the Occupational Therapists:

The great advances made by modern medicine in the treatment and rehabilitation of severely handicapped patients provide inspiration and satisfaction to all of us.

A spot check of known polio cases indicates that among 423,000 reported since 1938 there are many who might benefit by a medical reappraisal at this time.

The National Foundation for Infantile Paralysis is now compiling a nationwide roster of all post-polio cases to serve as a basis for an intensive study of their current medical needs. One of our chapter officials may ask your help in completing this roster. We have had your cooperation in the past and we know we can count on it again.

Of the 109,000,000 Americans under 40 years of age, more than 68,000,000 have already received at least one inoculation of Salk vaccine. For this remarkable achievement and for your continuing efforts to see that all receive the necessary three injections, you have the enduring gratitude of both the American public and ourselves.

Sincerely yours,

Thomas M. Rivers, M.D.
Medical Director
National Foundation for Infantile Paralysis

To the Editor:

I would like to especially commend to any who missed it, and to those who read it only once, a study of the material presented in Helen Creighton's article, "Law and the Youngest Member of the Medical Profession," as published in the last issue. Here is an article which clearly and logically outlines many legal considerations with which we should all be more familiar. A few additional points merit mention.

For example, the author notes that ". . . one tends to sue the person with the most money." This is true in many cases but a review of recent decisions in approximately parallel medico-legal cases indicates that lawyers and claimants tend to bring suit against all possible persons. Thus, while the hospital and the responsible physician might be sued, the occupational therapist is not immune simply by virtue of his relative financial status. Comprehensive liability insurance is now available to hospitals if they are approved and physicians may obtain insurance under these policies. Furthermore, a hospital is not liable for negligent medical acts if it can be proved that the institution has exercised "due care" in the selection of its medical staff and personnel. If negligence on the part of the therapist can be proved and injury results, the hospital is not liable if the therapist is technically qualified and the equipment sound; the doctor is not liable if he gave adequate *written* instructions *and* the hospital was responsible for the therapist's employment; thus, the therapist becomes the responsible party. But we should bear these facts in mind in another respect, i.e., with reference to the implied parallel respon-

sibility we would share in the case of injury resulting to a patient entrusted to the treatment of an occupational therapy student or aide under a therapist's general supervision. In such a case, we would unquestionably be "the person with the most money" and, as the doctor and hospital might be joined in a suit primarily against an occupational therapist but calculated to collect greater amounts, so we would become similarly involved in the event of injury to a patient resulting from negligence or malpractice of personnel under our jurisdiction.

The liability aspects in negligence cases raise another vital issue not covered in Creighton's article, namely: the importance of written medical referrals or prescriptions. Verbal orders will not hold up in court. Thus, if such are taken in person or by telephone, they should be countersigned at the earliest possible moment. Written referrals should also be obtained for evaluation of the patient prior to treatment, as is becoming standard practice by the medical team on admission and for purposes of planning a treatment program; if the therapist has to touch or move the patient in any way for purposes of this evaluation, he is responsible and should be covered by medical referral for that purpose.

The author warns that "good records can be most valuable in event or lawsuit." Occupational therapists should be aware of the fact that medical records are indeed assuming great legal importance in claims settlements. We should also be aware that records have significance for periods longer than those covering actual treatment: medical and hospital records are kept twenty years, on microfilm, past the Statute of Limitations, which varies among the states but is approximately seven years.

Laws are characterized more by uncertainties than by specifically predictable decisions. This is true because the law is subject to individual interpretations of judges and juries and determined in accordance with the somewhat vague course of action of what the "ordinary, reasonable man" would do. United States law is the most complicated of all law because it involves both the laws of the separate states and the laws of the federal courts, although the latter have limited jurisdiction. Miss Creighton wisely reminds us that "As in similar fields of employment, the legal aspects constitute a larger problem than many realize." It is to be hoped that, with this warning, with the exercise of constant care, with the avoidance of negligence, and—most of all—in consideration of the moral force of being entrusted with patient care, few of us will have to learn the importance of this area through personal experience.

Wilma L. West, O.T.R.

To the Editor:

With the increasing emphasis on the use of adapted devices to help patients become more independent in their activities of daily living, homemaking and vocational and avocational pursuits, I feel most O.T.'s are sharply aware of their need for further information on evaluating these devices either made in the O.T. department itself or purchased commercially. It has been a great boon to the profession to have had such a capable therapist as Miss Zimmerman concentrate her talents in developing this field.

As a department in a hospital which uses self-help devices and where the entire patient treatment program is well-integrated in the rehabilitation department, we are continually faced with decisions regarding the practicability of self-help devices for a particular patient. So much of Miss Zimmerman's article was an echo of what we have been trying to develop here in our adapted equipment shop. Many of her statements we could heartily endorse from our own experience. It is a great help to see such experiences written down.

But how can we give such information practically to new therapists in the field who will be making decisions on adapted equipment. Commercially purchased these devices can be expensive and I am sure every O.T. who has been in the field any length of time can easily recall cupboards full of trials and errors. These endeavors have been costly in time and materials and although many times the therapist learned, has he passed his information along in written form to help others avoid similar errors?

With Miss Zimmerman's paper we have a beginning to which we can add from our experience. We have an orientation for new therapists who come on our staff and who need further information on this complex aspect of a good treatment program. With this paper as the groundwork, we can add what we have observed in our particular working situation, and with the combination of the two eventually be able to present to new staff members a concrete and sensible approach to the use of adapted equipment. We have a small beginning in this hospital in that some self-help devices have been made by a skilled technician assigned to the O.T. department. These devices have included splints with adaptations, mouthpieces, special lapboards, feeding aids, etc.

In addition we have assembled the commercial devices purchased for use in our activities of daily living area as well as in our homemaking area and have evaluated them from our patient's needs and therapists' reaction toward such devices.

We are glad to have this material in print and hope that Miss Zimmerman will continue to publish her material.

Sincerely yours,

Susan P. Mahan, O.T.R.

To the Editor:

The writer is moved to comment on two stellar articles by Lilian Wegg and Robert Walker, respectively, published in the July-August issue. Because these columns have recently been devoted to a scholarly analysis of controversial issues in the area of pre-vocational appraisal, this letter will address itself largely to some philosophical speculations.

The contributions of Mrs. Wegg and Mr. Walker bear witness to a steadily mounting interest in the function of occupational therapy as it applies to pre-vocational evaluation. These writings are the more edifying by reason of thoughtful analyses, evidence of substantial advances in pre-vocational techniques, and recognition that the interdisciplinary approach is the bedrock of any successful pre-vocational appraisal program.

Both writers have, indirectly, but none-the-less forcefully, pointed up the folly of wasting precious time in an attempt to manufacture or install a new discipline where what is called for is essentially a synthesis of existing professional skills and talents. Mrs. Wegg illustrates the ingenious pooling of the occupational therapist's and the industrial engineer's skills to meet client needs. Mr. Walker implies a similarly rewarding relationship between vocational counselor and therapist. Other examples may be cited both in these articles and in fact.

The age of specialization has undoubtedly brought benefits in terms of particularized and refined skills. We submit that this same era of specialization has fostered destructive tendencies in human relations. Too many professionals today regard each other with suspicion and protest the natural responses of fellow workers which grow out of situational or individual client problems.

The corollary of this unfortunate circumstances is that the client becomes a target for a mass of splintered services, often overwhelming in profusion, too often impotent in their impact. The rage for specialization is reflected in our current struggles to carve out in the pre-vocational area a new territory and to quickly crown its new monarch.

These observations are not cited in refutation of existing limitations in the occupational therapist's armamentarium of pre-vocational techniques. Similar gaps may readily be recognized in the tool-kits of allied professions (and, in time-honored fashion, the youngest among these may well speak loudest in defense of standards, qualifications, revised curricula, etc.). But, let us remember that, as long as we progress, these inadequacies will haunt our path—the race is eternal.

The plea, then, is for the earnest, even dedicated, collaboration of the occupational therapist with counselor, engineer, psychologist and all others who will share with her their mutual knowledges to the end that each may grow in stature and potential service to our focus of concern, the client. Is it not full time for us to seek and discover new and more creative designs for combining our insights, information, techniques, instead of haggling about which brand of homo sapiens may perform in this area and at just what invisible point he has infringed the prerogative of the next man in line?

Improved formal education may be a partial answer to fortifying and enhancing our performance; but one might hypothesize that the same amount of effort, discharged country wide, into creative interdisciplinary relationships might produce a powerful forward surge in our theory and application of pre-vocational appraisal. Evidence confronts us in such proposed and actual programs as are outlined by the writers referred to above.

June Sokolov, O.T.R.

To the Editor:

Dr. Scheeley pinpoints a number of challenges to occupational therapy that have been in need of good review. For the sake of simplicity, let's divide these challenges into three parts and give them new handles by naming them *depth*, *breadth*, and *integration*.

Before extruding examples from his article to more clearly delineate these three, it may be appropriate to reiterate two big points the author makes:

1. The widely accepted policy of focusing greater attention on the more active psychiatric cases.

2. The fact that occupational therapists are not disinterested parties as the drugs are being tried.

The current use of these drugs could help us to raise our sights and broaden our focus to include more than what are now determined to be the "active cases." This widespread interest in the new drugs could well be a precipitating factor in the refinement of the pattern of occupational therapy in psychiatry.

Now, the three challenges he makes. First, those of a depth nature. Examples here are:

1. Timing of the application of therapy must be just right.

2. Attitude therapy will be more meaningful and difficult.

3. Communication and interpretation will be increasingly important at levels of prescription, progress notes, and staff conferences.

Then the challenges of breadth:

1. Greater numbers of patients will be referred to occupational therapy.

2. More group activities will need to be utilized.

3. Variety and complexity of activity will increase. This will be coupled with the necessity to "keep patients moving" through ward and off-ward activities and satisfying human relationships.

The third challenge is in integration:

1. Occupational therapy will be expected to serve as a gateway to industrial therapy, vocational training and vocational placement.

2. Occupational therapists must belong on the team.

3. Occupational therapists must assist in the overall therapeutic plan.

More power to the ataraxic drugs and Dr. Scheeley for bringing these challenges directly to us. Certainly the present widespread interest in, as well as effects of these drugs will probably be substituted by other interests and effects in a few years. Then they will fall into better perspective with the other widely used, tested, and accepted therapies such as electroshock and psychotherapy. The implications Dr. Scheeley reports from the early therapeutic effects of them, however, bring glimpses of our potential future direction in psychiatry. The challenge to grow up, to take responsibility, to extend ourselves, to determine and strengthen our individual and collective areas of functional responsibility, are clearly before us.

Some of us will seek a major role in the *depth*—developing new techniques, refining and perfecting the old as well as researching and working with special groups. Others of us will perform with greater efficiency and comfort in the area of *breadth*. This is the scope of the occupational therapy program and encompasses a wide variety of the work (vocationally related) and play (avocationally related) activities. Still others of us will make our greatest contribution in the *integration* area. This is the area of records, scheduling and supervision. The education program so vital for us to perform at so many levels (volunteers, aides, media specialists, O.T.'s, nurses, physicians) may be closely related to this area. All of us will need some professional education in all three; many of us will be doing all three; some of us will specialize.

We are more familiar with these three—depth, breadth, and integration—when we haul out the old familiar names: "intensive or functional treatment," "supportive, milieu, or environmental" aspects of our work, and "administration and education." The refinement of these three areas of functional responsibility are the challenge Dr. Scheeley makes to occupational therapy in psychiatry in 1957. These are not coordinates or equal parts; they all have distinct and different properties that makes a significant contribution to the total occupational therapy program.

Barbara Locher, O.T.R.

Fellowships—Physical Medicine and Rehabilitation. Available immediately, one at first-year level and one at second-year level. Stipends $3,400.00 per annum at first-year level; $4,400.00 at second-year level. Board and Laundry privileges provided, housing if available at time of application. Further inquiries should be directed to:

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Reviews

REHABILITATION LITERATURE 1950-1955, Earl C. Graham and Marjorie M. Mullen. New York: McGraw-Hill Book Co., 1956, 573 pp., $13.00.

An all-inclusive bibliography of rehabilitation literature from 1950 through 1955. The references relate to specialty areas and all types of disabilities are covered in this volume.

This material should prove of great value to all occupational therapists interested in study, research and further references relating to a specific condition. The listings carry a brief annotation to enable the referrer to evaluate the material according to his needs.

CLINICAL EXAMINATIONS IN NEUROLOGY. Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation. Philadelphia: W. B. Saunders Co., 370 pp., 1956.

This material was prepared to help the physician master the clinical neurologic examination, however, it can also be of considerable value to the occupational therapist who is working with neurologic patients. Of importance to the therapist is the information on the clinical examination of the cranial nerves, sensory nerves, and motor function. The discussion of motor function includes central integration, variations in muscle tone and coordinate movement. Muscle action is specifically studied and methods of testing selected muscles presented. The nature of normal and pathological reflexes and testing for them is included as is the sensory examination (touch, position sense, vibration, astereognosis and the like.)

Also covered is the evaluation of the autonomic nervous system and mental function disturbed by neurologic disorders. The latter includes retention, judgement, thought content, apraxia, language and motor speech. The clinical examination through electroencephalography, electromyography, biochemistry, pharmacology, and cerebral spinal fluid is presented.

Throughout the book sufficient medical information related to the anatomy pathology, and symptomatology of the area under examination is presented to make worthwhile the use of the book for reference to these processes, regardless of whether or not the therapist intends to familiarize himself with examination techniques.

—A. Jean Ayres, O.T.R.

PHYSICAL MEASURES IN THE AGED. Donald Rose, M.D., Edward Shires, M.D., and Wm. Alyea, M.D. *The Journal of the American Medical Association*, 162:17 (December 22) 1956.

The purpose of this paper is to discuss disturbances in bodily functions produced by acute and chronic hypoxia in the elderly patient, and to demonstrate the need for improving the efficiency of external respiration and for emphasizing early ambulation in their rehabilitation program.

Frequently in the aged patient, reduction in the efficiency of pulmonary function is so marked that effects of hypoxia enter into the original disability. Improvement in respiratory function, it is stated, has been accomplished by use of specific breathing exercises plus mechanical efforts to increase pulmonary air flow. General condition as seen in exercise tolerance and emotional attitude reportedly showed definite improvement as well, after such a program. In line with this thinking is the conviction of the authors that early attempts at ambulation —standing and walking—are more important in this case than concentrated effort on reeducational exercise for separate groups of weakened muscles. Supplemented by graded exercise procedures, the rehabilitation period is believed to be greatly shortened for these patients.

—D. R. Street, 1st Lt., AMSC.

A NEW APPROACH TO SCHIZOPHRENIA, Julius I. Steinfeld, M.D. New York: Merlin Press, Inc., 1956, 195 pp., $4.95.

This research work emphasizes the theory of the "hunger trauma" occurring the first few weeks of human existence. The possibilities of tendencies developing toward abnormal vegetative reactions and the importance of the regulating function of the diencephalon are explained. Treatments by acetone inhalation are being experimented with to reproduce the same physiological phenomenon in psychotic adults as that conditioned by the "hunger trauma," thereby determining, if possible, the "basis for changes in the schizophrenic process." Thirty-one case studies are reviewed. A glossary and bibliography are contained in the appendix.

—Bertha J. Piper, O.T.R.

STILL GOING PLACES! ACTIVE MANAGEMENT OF DISABILITY IN THE AGED, 16mm, black and white, sound, 40 minutes, free loan, Pfizer Laboratories, Film Library, 630 Flushing Avenue, Brooklyn 6, N.Y.

The film portrays examples of elderly disabled patients who are, through programs of early and continued activity, prevented from becoming bedridden. Among the physical disabilities presented in the aged are: cardiac, Parkinsonism, bilateral amputee, hemiplegia, severe rheumatoid arthritis, and intertrochanteric fracture. Several different cases are followed through their active rehabilitation program.

—Harold Shalik, O.T.R.

FRACTURES IN THE AGED. Carter R. Rowe, M.D., and Robert Detwiler, M.D. *The Journal of the American Medical Association*, 162:17 (December 22) 1956.

In the population today the percentage of aged persons is gradually increasing, and with this increase come problems specific to this age group. The unique treatment of fractures in the aged is the problem selected for study in the present article, based upon a survey conducted at Massachusetts General Hospital in 1955. Statistical evidence reveals that patients 70, 80, or 90 years old constituted 25% of admissions; that females sustained fractures three times as frequently as males; and that in this group, fractures of the hip was the most common fracture (35%). Over-all mortality rate for aged persons on the fracture service was reported at 10%.

Characteristics of the aged patient are reviewed, with the possible complications that may arise with fractures or the co-existence of other disease as cause of disability. The factor of age itself is not considered to contraindicate surgical measures. Sedation, anesthesia, splinting, casting, fixation, and postoperative exercise are discussed with their effect on the general attitude and progress of the aged patient.

Fractures of upper and lower extremity are studied with regard to site, bone condition and treatment of choice. In fractures of the upper extremity, the primary

aim is seen as restoration of a useful hand, with minimal pain, stiffness, or limitation of motion in wrist, elbow and shoulder. In fractures of the lower extremity, restoration of weight-bearing and relief of pain are paramount, with mechanical aids frequently employed to allow early ambulation. Since 1931 with the introduction of the three-flanged nail as a means of stabilization of the hip, the handling of this major fracture problem has been brought under control.

Following hospitalization, it is felt that there is an urgent need for the long term care of aged patients in their period of convalescence. Only by a continuation of organized care can rehabilitation hope to be complete.

—D. R. Street, 1st Lt., AMSC.

AN EXERCISE PROGRAM FOR THE BRAIN-INJURED. Mary Jane Torp, Capt., AMSC (PT). *The Physical Therapy Review*, 36:10 (October) 1956.

A program for the treatment of traumatic brain-injured patients was developed at Tokyo Army Hospital in Japan during the period from 1952 to 1954. Neuromuscular facilitation technics (*Physical Therapy Review*. September, 1956, pp. 577-586) formed the basis for this program.

A detailed physical therapy program for one patient is given to illustrate the facilitation technics most commonly employed in reeducation of the brain-injured patient.

Because of the high patient load, a program was devised in which each patient could do as much as he was able for himself. A warm-up period during which the patient worked under the supervision of a non-professional person preceded the individual treatment period.

Speed and efficiency were essential in order that each patient gain reciprocal voluntary function in all extremities before he left Japan. If this goal was attained postponement of treatment during transit might not lead to muscle imbalance or regression in function. Facilitation technics permitted an aggressive approach to reeducation. Following closely was a program of early ambulation.

It is hoped that some aspects of this program, such as organization for scheduling the treatment load and early emphasis on self-help activities, might be of interest to civilian hospitals as they are contemplating the treatment of possible mass casualties.

—Maryelle Dodds, Capt., AMSC (OT), M.A.

PHYSICAL THERAPY IN A NEUROPSYCHIATRIC HOSPITAL. Charles M. Kinnard, M.A., and Delilah Riemer, M.D. *The Physical Therapy Review*, 36:10 (October) 1956.

In a neuropsychiatric hospital physical therapy is frequently prescribed for the same type of disorders as are found in a general medical and surgical hospital, but the psychiatric disorder is superimposed on, and sometimes sponsors, the physical disorders. In order to treat the neuropsychiatric patient effectively, the therapist must understand the patient and be prepared to deal with any possible reaction he might have to the modality being used.

Treatment procedures for certain physical disorders common to psychiatric patients, such as venostasis, clenched hands, hyperhydrosis and ecchymosis, are discussed. Psychiatric manifestations such as hyperactivity, hypoactivity, and pseudopain may also be benefitted by various types of treatment given by the physical therapist.

—Maryelle Dodds, Capt., AMSC (OT), M.A.

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Registered occupational therapist, male or female, to head department in outpatient rehabilitation unit connected with university medical center. Position available late fall with opening of new building. Salary open. Contact Executive Director, Medical Center Rehabilitation Unit, University of North Dakota, Grand Forks, North Dakota.

University medical center—registered occupational therapists. Directorship and staff positions available in department of psychiatry. Modern teaching hospital with 72 psychiatric beds. Work in close cooperation with psychiatric training program. Well-equipped facilities which are just being expanded. Situated in small university town with unusual cultural and recreational facilities. Salary: director, $4456 to $5376; staff, $3516 to $4312. Three weeks paid vacation plus holidays, two weeks sick benefits. Write for details and applications to George C. Ham, M.D., Chairman, Department of Psychiatry, University of North Carolina, Chapel Hill, N. C.

Immediate vacancies for registered occupational therapists in Rochester, Minnesota, one of the Midwest's finest and fastest growing communities. Private employment—out-patient and hospital services, psychiatry, physical disabilities, ADL, recreation. Very liberal benefit program. Write Personnel Section, Mayo Clinic, Rochester, Minnesota.

Immediate opening for director of occupational therapy department. Salary open. Pleasant surroundings and working conditions. OT dept. now operating in the New Norfolk State Hospital Administration Building, with spacious quarters, new and modern equipment. Contact Dr. C. G. Ingham, Supt., Norfolk State Hospital, Norfolk, Nebraska.

Registered female occupational therapist for staff position in university center hospital. Knowledge of women's crafts is essential. Write to Mr. R. Nagorka, O.T.R., Director of OT Dept., Psychiatric Institute, 645 West Redwood Street, Baltimore 1, Maryland.

In the New York State tuberculosis hospitals, occupational therapy is a dynamic part of the patient's rehabilitation program. Therapists are wanted who are interested in maintaining this concept. Beginning salary is now $4502. For further details contact: Supervisor of Occupational Therapy, New York State Department of Health, Division of Tuberculosis Control, 84 Holland Avenue, Albany 8, New York.

Registered occupational therapists for 300 bed private neuropsychiatric hospital, 25 miles from New York City. Clinical training program; group insurance, retirement and other personnel benefits. Salary commensurate with experience. Maintenance optional. Write Mrs. E. S. Owen, O.T.R., The New York Hospital, Westchester Division, 121 Westchester Avenue, White Plains, New York.

O.T.R. interested in accelerated program for 200-bed tuberculosis sanatorium. Modern and well-equipped OT and rehabilitation department of eight staff. Advancement to assistant and director when capable. Experience not necessary but must have good command of crafts and interest in fast expanding program. Write W. E. Wavering, Rehab. Dir., St. John's San., Springfield, Illinois.

Registered occupational therapist for new admissions building in psychiatric hospital 12 miles out of Boston. Salary range $3,328-$4,264. For further information contact: Miss Helen Storr, OTR, Head Occupational Therapist, Metropolitan State Hospital, Waltham 54, Mass.

Two O.T.R.'s needed for expanding program in a progressive training center for mentally retarded and epileptic. Scope of O.T. includes treatment of physical disabilities and emotional disturbances, as well as help in initial adjustment to institution and ADL. Two new buildings; congenial staff of 5; flexible program, which is medically supervised. Salary range $3600-$4200, depending upon experience; meals, laundry and medical care furnished; housing available for single person. University of Florida and Medical School in same town: beaches within 100 mile radius. Mrs. Grace A. Straw, Chief Occupational Therapist, Sunland Training Center, Gainesville, Florida.

Staff position open for registered occupational therapist. Salary open. Pleasant surroundings and working conditions. Contact Dr. C. G. Ingham, Superintendent, Norfolk State Hospital, Norfolk, Nebr.

Position for occupational therapist open Hamilton, Ohio. Therapist to work at school for crippled children also general hospital experience. Apply Butler County Society for Crippled Children, 405 Rentschler Bldg., Hamilton, Ohio.

Immediate opening for registered occupational therapist, male or female, in well equipped rehabilitation institute of the Boston Dispensary. Patients referred from all treatment and diagnostic units of the New England Medical Center and from out-patient clinics. Varied case load, mainly adults. Program consists of evaluation, self-help activities, functional and pre-vocational therapy. Challenging opportunity in an expanding program. Moving into new rehabilitation building early in 1958. Salary open. Apply to Personnel Director, New England Medical Center, 37 Bennet Street, Boston, Massachusetts.

Male occupational therapist—to supervise large vocational shop. Salary commensurate with demonstrated ability. Good personnel policies, paid vacation, sick leave, Blue Cross-Blue Shield, annual salary increment, 37½ hour week. Crossroads is in a beautiful new building, well equipped and nationally recognized as a leader in the field of rehabilitation. This is a real opportunity. Write Roy E. Patton, Executive Director, Crossroads Rehabilitation Center, 3242 Sutherland Ave., Indianapolis, Indiana, or call WAlnut 6-2482.

Enlarging our staff—opportunity for registered staff therapist in a modern tuberculosis hospital. Dynamic approach to total patient rehabilitation. Five day, 40-hour week, sick leave, paid vacation and holidays. Salary commensurate with experience. Contact Mr. W. C. Anderson, Executive Director, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

Registered occupational therapists. California has fourteen new positions in its state hospitals open now to graduates of approved schools of occupational therapy. Monthly salary starts at $376; opportunities in mental hospitals for advancement to $644. *Lee Helsel, state's representative, will interview applicants at national conference of Occupational Therapy Association October 21-25 in Cleveland.* Inquire at registration desk for Mr. Helsel. Applications will be accepted until November 14 for civil service examinations in all states. Write State Personnel Board, 801 Capitol Avenue, Sacramento, Calif.

Registered occupational therapist for 29 bed diagnostic psychiatric unit at Hartford Hospital. Liberal fringe benefits. Community offers fine academic and cultural environment. For further information write to the Personnel Department, Hartford Hospital, 80 Seymour St., Hartford 15, Conn.

A wonderful opportunity—progressive rehabilitation center, in and out patient, full rehabilitation team, educational, dynamic OT program stressing functional therapy, ADL training, homemaking and avocational interests for varied patient load. Large, well-equipped, new training kitchen. Salary open, one month vacation, sick leave, 40 hour week, uniform laundry, lunches, health insurance, annual increment on merit. Ideal location—just 40 minutes from New York City, yet in suburb which provides many cultural and recreational opportunities. Contact Miss Joan Caspersen, O.T.R., Burke Foundation, Mamaronek Ave., White Plains, New York.

Wanted—occupational therapist—210-bed hospital for chronic diseases and tuberculosis. Salary $3,744.00 to $5,096.00. Forty-hour week. Two weeks sick leave. Three weeks vacation. Social security and optional retirement plan. Living quarters and laundry can be furnished at $5.00 per week. Apply to H. D. Ireland, M.D., Sunshine Hospital, Grand Rapids 3, Michigan.

Occupational therapist. The Flint Civil Service Commission has an opening for an ocupational therapist at Hurley Hospital. The person selected will help organize the new occupational therapy department at Hurley, which has 629 beds. Salary range is $4,654-$5,577. For further information write: Flint Civil Service Commission, City Hall, Flint 2, Michigan.

Registered occupational therapist for small hospital for convalescent children and rehabilitation center for children and adults. Well equipped department, 5-day, 40-hour week, 4 weeks vacation with pay, 10 paid holidays, sick leave, good salary, pleasant surroundings. For further information apply Superintendent, Sol-e-Mar Hospital, South Dartmouth, Massachusetts.

Challenging position of organizing, supervising and conducting an OT program on one section of the hospital for approximately 300 patients available to registered OT, male or female, in progressive psychiatric hospital located 40 miles south of Kansas City. Require person with knowledge of human dynamics and experience in administering therapy to mentally ill patients. Holiday, vacation, and sick leave benefits, maintenance available, semi-annual salary increases. Salaries $3,708-$4,092. Write Robert O. Perry, Coordinator of Adjunctive Therapies, Osawatomie State Hospital, Osawatomie, Kansas.

Wanted: registered occupational therapist for general hospital with established psychiatric department. Write to Personnel Office, St. John's Hospital, 1235 E. Cherokee, Springfield, Missouri.

Occupational therapist to take full charge of an active department in a 350 bed general teaching hospital and to be in charge of occupational therapy students from an affiliated school. Forty hour week, one month's vacation plus other liberal personnel benefits. Salary $4,600 per year. Write Mr. Edwin L. Taylor, Director, The Graduate Hospital, Philadelphia 46, Pa.

Venice of America—OTR to head newly organized department in out-patient treatment center. Beginning salary $3600 to $4000 depending upon experience, 5 day week, 8 paid holidays, month's vacation. Write Mrs. Mildred Sierra, Director, Easter Seal Clinic, Bldg. 8, Naval Air Station, Ft. Lauderdale, Florida.

Occupational therapist to develop program for emotionally disturbed children in new building 10 miles from Boston. Salary range: $3,328-$4,264. For further information contact: Miss Helen Storr, O.T.R., Metropolitan State Hospital, Waltham 54, Mass.

Occupational therapist, immediate opening. Salary $4,329.00-$5,529.00 yearly. Therapist who is willing to play a role in the development of a dynamic program. No experience required. Apply Activity Program Coordinator, Allentown State Hospital, Allentown, Pennsylvania.

Director, occupational therapy. Immediate opening, salary $5,529.00-$7,055.00 yearly. Need person who wants to work to develop a dynamic treatment program in a hospital ready to support such a program 100%, must have imagination, ability to organize and promote harmonious relations with others. Contact Activity Coordinator, Allentown State Hospital, Allentown, Pennsylvania.

Excellent opportunity for you to use your knowledge and abilities developing an outstanding program. Preference given registered occupational therapists with supervisory experience. Good employee benefits. Please send resume of training and experience to Chief of Personnel Services, Board of Texas State Hospitals and Special Schools, Box X, Capitol Station, Austin, Texas.

Registered occupational therapist for work in general hospital having medical, surgical, orthopedic, prosthetic and psychiatric patients. Opportunities for research. Salary $3,840-$4,704, contingent on experience. Personnel policies include annual four weeks paid vacation, sick leave benefits, insurance, and retirement plan. Write: Miss Jane Calvert, Chief Occupational Therapist, The John Hopkins Hospital, Baltimore 5, Maryland.

Wanted: occupational therapist, for 86 bed tuberculosis sanatorium and infirmary for the aged. Female preferred. Salary open. Complete maintenance available on hospital grounds without charge. Write Raymond H. Evers, M.D., Rocky Knoll Sanatorium, Plymouth, Wis.

Excellent position available for a staff therapist to work with cerebral palsied children. Experience not necessary. Starting salary dependent upon qualifications. Good working conditions. Contact Freeman P. Fountain, M.D., Medical Director, United Cerebral Palsy of The Falls Cities, 600 East Broadway, Louisville 2, Kentucky.

OTR for crippled children's school, 9-months term beginning September 1. New building; air conditioned; central heating. Large OT department; well equipped. School holidays and hours; sick leave. Good salary, advancement. Write Joe D. Ellis, Executive Director, Hughen School, 3620 28th Street, Port Arthur, Texas.

Position open for qualified occupational therapist in new 30 bed psychiatric teaching unit. Salary up to $5,000, depending upon qualifications. Contact Dr. Wm. G. Reese, Professor, Dept. of Psychiatry, Univ. of Ark. Sch. of Med., Little Rock, Ark.

Wanted: occupational therapist, salary $3456 to $4320. Large mental hospital. Liberal vacation and sick leave plan. Regular increases. Some living quarters available. Apply Personnel Office, Central State Hospital, Box 271, Petersburg, Va.

Long Island Hospital, Boston, has openings for occupational therapists to work with an alcoholic rehabiltation program—40 hour week—sick benefits—vacation—room and board if desired. This program is recognized by the Yale University School for Alcoholic Studies. Write Superintendent John R. McGillivray, Long Island Hospital, Boston 69, Massachusetts.

Wanted immediately: occupational therapist for small neuro-psychiatric department. Salary open. Varied duties, including teaching a 10-hour course to student nurses every three months. Write Thomas L. Foster, M.D., The Hertzler Clinic, Halstead, Kans.

Occupational therapist: for well organized, therapeutically orientated program in progressive psychiatric hospital, located within the city limits of Lexington, Kentucky. New intensive treatment building with well planned and fully equipped occupational therapy shop about to be opened. University of Kentucky, close by, offers educational and cultural advantages. Salary commensurate with experience, 40 hour week, paid vacation and sick leave, 13 holidays per year, opportunity for advancement to assistant director's position, excellent living accommodations for single person. Contact: Mrs. Frances Jonakin, Occupational Therapy Consultant, Eastern State Hospital, Lexington, Kentucky.

Occupational therapists for 4500-bed modern progressive mental hospital. Must be registered or eligible for registry in American Occup. Ther. Assn. Start at $376; annual increases. Civil service. Three wks. paid vacation; sick leave; 11 paid holidays. Fine recreational area; 66 miles east of Los Angeles. Write Supt., Patton State Hospital, Patton, Calif.

Position open: supervisor clinical affiliation, Colorado State University. Salary and academic rank dependent on qualifications and experience. Faculty privileges include: 5 hours course work per quarter, tuition free. Clinical experience in supervising students desirable. Information: Marjorie Ball, Director, OT Course, Colorado State University, Fort Collins, Colorado.

Therapist wanted: salary open. Opportunity for postgraduate training in the field of cerebral palsy under scholarship. One month paid vacation, holidays, including extended Christmas leave. Program well established and still developing. For further information write to director, Mrs. Victor Warken, Cerebral Palsy of Columbus and Franklin County, Inc., 523 E. Walnut St., Columbus 15, Ohio.

Work evaluation: staff therapist to help expand and conduct program specifically designed for exploration and evaluation of job potentials for all disability areas —physical, mental, cardiac, Tbc, retarded, etc. Program utilizes work samples, functions as key unit in integrated program of vocational rehabilitation counseling and adjustment in strong community agency; full counseling staff, separate transitional workshop, placement services. Close liaison with Western Reserve University and all local hospitals. Research potentials. Write Karl L. Ireland, OTR, Supervisor, Work Evaluation and Occupational Therapy, Vocational Guidance and Rehabilitation Services, 2239 E. 55th St., Cleveland 3, Ohio.

Immediate opening for registered occupational therapists in the 2,300 bed State Hospital. Challenging and interesting opportunity in growing OT department. Salary $335.00 to $485.00 per month depending upon experience. Liberal civil service benefits. Limited maintenance facilities available at $25.00 per month. Contact Dr. C. L. Williams, Superintendent, Central State Hospital, Indianapolis, Indiana.

Immediate opening for position of director of department of occupational therapy in progressive psychiatric center associated with the medical school of the University of Michigan. Physical setup includes four units for intensive treatment of children, adolescent and adults, with occupational therapy and recreational therapy supervisors on each unit. Student affiliation center. Qualifications: B.S. Degree, OTR; minimum of 4-6 years in occupational therapy, with extensive experience in treating psychiatric patients, in training students, and in administration. Generous personnel benefits; salary open. Address communications to the Personnel Department, University Hospital, University of Michigan, Ann Arbor, Michigan.

Immediate openings for registered occupational therapists and graduates of approved schools eligible for registration, in 2000 bed chronic disease hospital affiliated with New York Medical College. Positions available in children's rehabiiltation, adult rehabilitation and sheltered workshop. Modern facilities, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit. Write Mr. William D. Kamper, O.T.R., Bird S. Coler Hospital, Welfare Island 17, New York.

Occupational therapist for children's orthopedic hospital and rehabilitation center located 32 miles from New York City, in Valhalla, New York. Salary open. Contact Jacob Reingold, Executive Director, Blythedale, Valhalla, New York, Tel.: LYric 2-7555.

Immediate placement for registered, qualified occupational therapist for supervisory position in rapidly expanding physical medicine and rehabilitation institute serving two hospitals, total 1,000 general medical and surgical beds, in largest centrally located industrial center in Illinois. Experience in supervisory position and in comprehensive rehabilitation center necessary. Salary $4,800-$5,400. Write: Administrator, Institute of Physisal Medicine and Rehabilitation, 619 North Glen Oak Avenue, Peoria, Illinois.

Wanted immediately: Occupational therapist for large visiting nurse association planning extension of home services for the chronically ill. Challenging opportunity to participate in an expanding program in a progressive city. Good personnel policies. Salary open, around $4500.00. Apply stating particulars of preparation and experience to: Executive Director, Visiting Nurse Association of Allegheny County, 200 Ross Street, Pittsburgh 19, Pennsylvania.

Wanted—2 registered occupational therapists; one as assistant chief and the other a staff therapist in a rehabilitative unit of a general hospital. Salary open Liberal personnel policies. Contact Miss Anne Drag, OTR, Ocupational Therapy Department, St. Vincent's Hospital of N.Y.C., 11th St. and 7th Avenue, N. Y. 11, N. Y.

Modern recuperative center desires mature therapist to take charge of occupational and recreational program. Salary arranged. Excellent personnel policies. Write Miss Leah Nataupsky, R.N., Director, The Recuperative Center, 1245 Centre Street, Roslindale 31, Mass.

Staff OT wanted immediately for work in expanding rehab center. Services include P.V. unit, sheltered workshop, braceshop, job placement. Starting salary $4200. 20 days vacation, 12 days sick leave. Student training center for University of Pittsburgh. Write Mrs. Mona Durgin, O.T.R., Harmarville Rehabilitation Center, Pittsburgh 38, Pa.

Registered occupational therapist, full time employment—open now—in general hospital, 500 beds—part time to be spent in physical medicine department under direction of physiatrist, part time psychiatric service under direction of psychiatrist—new department—challenging opportunity—salary open, would meet any reasonable salary—5 day week. Write or call Harriette Oeftiger, Personnel Director, Charles S. Wilson Memorial Hospital, Johnson City, New York.

Wanted: for teaching, research hospital center, two psychiatric occupational therapists. Beginning salary $4270.00. Write: Syracuse Psychiatric Hospital, Box 27, University Station, Syracuse 10, New York.

Wanted: occupational therapist with some experience in an acute 100 bed psychiatric treatment center located in medical center of Cincinnati. Pleasant and stimulating opportunity. Contact Dr. C. O. Ranger, 3009 Burnet Avenue, Cincinnati 19, Ohio.

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Education: Completion of a recognized course in occupational therapy.

Experience: One year, after completion of the required education, or supervised experience in occupational therapy, preferably with some experience working with cerebral palsy children.

Apply: James C. Malcolm, M.D., M.P.H.
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For further information contact:

ROBERT L. BENNETT, M.D.
Medical Director

Georgia Warm Springs Foundation
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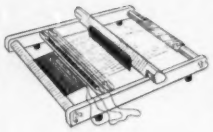
TABLE LOOMS



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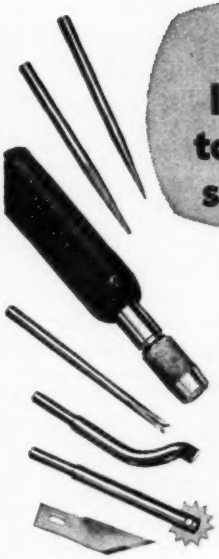

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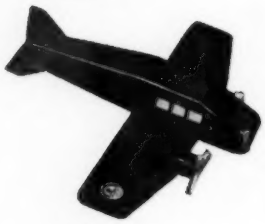

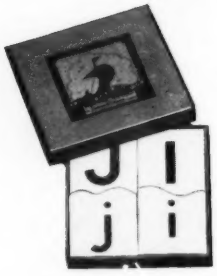

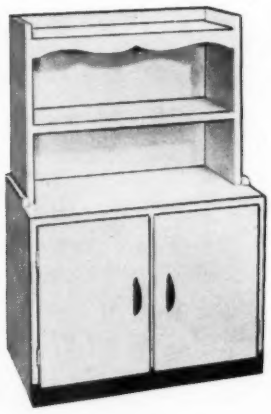

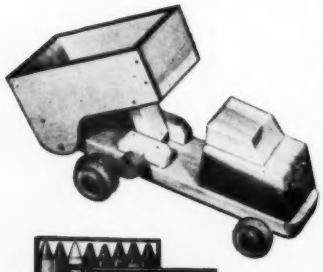

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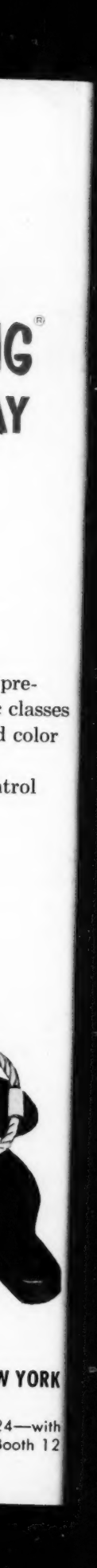
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